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ABSTRACT

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CLINICAL INTERNSHIP TRAINING PROGRAM IN PSYCHIATRIC VOCATIONAL REHABILITATION

**Funded by the U.S. Department of Education
Rehabilitation Services Administration**

**Michelle O. Geckle, M.Ed., CRC
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TRAINING MANUAL

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In addition, there is a complete Seminar Series which includes lectures, reading materials, and case study exercises.

The content of the Seminar Series is intended to complement clinical field work with didactic educational materials. Each section of the seminar series includes exemplary or seminal articles related to a particular topic.

TRAINING OBJECTIVES

The training program in psychiatric vocational rehabilitation is designed to provide a highly specialized and intensive training program for individuals pursuing a master's degree in rehabilitation counseling or for individuals with no formal education beyond the bachelor's degree who are currently employed in the rehabilitation field. The contents also lend themselves to a credit course format (three credits for the didactic seminar series; three credits for the field work).

The training objectives involve:

(1) Supervised training in the practice of interagency collaborative experiences, vocational assessment and counseling, and job development and placement with a focus on clients who have a major psychiatric disability.

(2) Facilitating multi-cultural learning experiences through didactic information and client contact.

(3) Providing up-to-date information with regard to the major psychiatric disorders and their treatment.

(4) Demonstrating how to successfully collaborate between mental health and vocational rehabilitation agencies and programs utilizing a team work model.

(5) Teaching how to identify and access necessary community resources for individuals with minimal in-place support systems.

(6) Providing appropriate professional mentoring which includes a code of ethics and concordant standards of practice.

(7) Developing the skills necessary to facilitate personal empowerment in persons with psychiatric disorders.

TRAINER REQUIREMENTS

In order to successfully implement this training package, certain staff competencies will be necessary, either in place in the field site or available through a program of consultation. This statement is made not to demean the vast experiences of many individuals practicing in psychiatric rehabilitation across the country, but to acknowledge the breadth and depth of the training program itself. For example, many individuals will not be prepared to teach the seminar dealing with psychotropic medications. Thus, a local psychopharmacologist, psychiatric nurse practitioner, or physician's assistant might be called upon to engage in the training program. A drug and alcohol specialist may assist with dual diagnosis clients and related issues. A licensed psychologist should be available to provide instruction and supervision in the utilization of the various psychometric procedures which require their special credentials and level of expertise. In order to obtain the maximum benefit from this training program, access to a multi-disciplinary setting is highly preferable. Finally, sections of the training manual may be extracted for use by individuals with particular interest areas or background training who may wish to use these sections as part of another ongoing course or as discrete workshop topics.

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    Group Seminar/Supervision Meetings

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        Universal Precautions
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In katz (Ed). Psychiatric rehabilitation: A handbook for practiti
St. Louis: Warren Green Publishers, 1992.

Chapter I

PSYCHIATRIC REHABILITATION: THE INTERDEPENDENCE OF TWO WORLDS

LYNDA J. KATZ, PH.D.

INTRODUCTION: A HISTORICAL PERSPECTIVE

The first non-military vocational rehabilitation legislation, The National Civilian Vocational Rehabilitation Act (P.L. 66-236) also known as the Smith-Fess Act, became law on June 2, 1921. Some twenty years later, in 1943, major revisions were adapted (P.L. 78-113) which not only brought the field of medicine into the vocational rehabilitative process but also made special provisions for the rehabilitation of individuals who were blind and those having mental disabilities. It has been said that the concepts of rehabilitation have derived mainly from work with the physically disabled (Bloom, 1965). No special efforts were made to evaluate whether or not the operationalization of these concepts with the mentally disabled was equally effective, particularly since the vast majority of these individuals were incarcerated in large public institutions, far removed from the concern of community-based agencies or facilities. With the advent of the use of psychotropic medications in the late 1950's, which was heralded as the greatest contribution of psychiatry to the care of the mentally ill since the psychodynamic formulations of Sigmund Freud, the movement to "deinstitutionalize" these large, overcrowded and dehumanizing public hospitals began.

Within twenty years of the Barden-La Folette Act (P.L. 78-113), the Community Mental Health Centers Act of 1963 (P.L. 88-164) became law, ushering in the era of community psychiatry, a new philosophical base for treatment of the mentally ill. The goals of this new approach to treatment included: (1) the provision of service in the individuals' community; (2) the location of facilities near the patients' home; (3) the provision of a comprehensive range of services; (4) the establishment of services which were both immediately available and easily accessible; and (5) the assurance of continuity of care until restoration or rehabilitation was completed (Dorsett, 1964). However, contrary to the early "prevention-oriented" idealism of the early community mental health movement were the realities of the masses of deinstitutionlized chronically ill patients who were moving into the community. While mental health centers were obligated to provide services for all the residents in their respective attachment areas, the provision of "rehabilitative" services was not one of the five mandated services. Those services which did develop for the patient with chronic mental illness were aftercare and partial hospitalization, both of which were clinical and followed a medical model.

With the 1975 Amendments to the Community Mental Health Centers Act (P.L. 94-63) rehabilitation was deleted as one of the possible services to be offered and transitional services, primarily residential in nature, were added to the new mandated services.

> It seemed that the professionals operating the mental health centers not only were not given the resources to develop rehabilitation services, but were more inclined to think in terms of transitional, treatment oriented services for this population (Rubin, 1980, p. 93).

At about the same time, the Vocational Rehabilitation Act of 1973 (P.L. 93-112) placed a priority on services to the severely disabled, the chronic psychiatric population being one of those groups eligible. However, each state was given discretion in how it would serve this new population. By 1978, the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments (P.L. 95-602) stated clearly that: (1) The Rehabilitation Services Administration (RSA) had a responsibility to meet the vocational needs of the severely mentally disabled; that (2) RSA's responsibility extended to those without a clear potential for independent competitive employment; and finally that (3) States had the option of establishing "Centers for Independent Living" (Rubin, 1980). The mandate for RSA funding for non-vocational rehabilitation services was established.

The NIMH/RSA Agreement

Such was the dilemma that must have faced administrators in the human service field in the late 1970's: (1) a federal/state rehabilitation program with funds to serve a population of individuals with a chronic/severe psychiatric disability; (2) an earlier discretionary mandate to the individual states who comprise the federal state vocational rehabilitation system, which was then amended in the form of a "nondiscretionary" mandate to provide vocational services to this population; (3) a community mental health program with no mandate and no funds or only categorically pre-determined funds to provide rehabilitation services to this population; and finally, (4) a severely disabled population in need of both services. Then in 1977, the National Institute of Mental Health established guidelines for the development of Community Support Program (CSP) demonstration efforts (Turner and TenHoor, 1978). A CSP was defined as: "A network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being necessarily isolated or excluded from the community" (p. 329). The target population for CSPs was adults with a severe or persistent mental or emotional disorder that seriously limited their functional capacities relative to primary aspects of daily living. In order to implement a CSP, the guidelines also specified the existence of a "core service agency," which regardless of the number of direct services provided, must take responsibility for a variety of integrative functions aimed at preventing the severely disabled from becoming isolated in the community.

Community support programs (CSP) and the philosophy underlying their establishment provided a natural meeting point for the philosophies of mental health and rehabilitation (Grantham, 1980). Under the leadership of the CSP staff, a National Institute of Mental Health/Rehabilitation Services Administration Cooperative Agreement was signed in May of 1978. Of equal importance was the fact that this agreement paved the way for the establishment of formalized working relations on state and local levels between the mental health and rehabilitation systems. Three major issues involved in service delivery to persons with chronic psychiatric disabilities were recognized in this cooperative agreement:

> (1) The chronic psychiatric population needs long term availability of support services. This has not been a priority by Community Mental Health Centers over the last decade.
> (2) Funding to support necessary services for the chronic psychiatric population cannot be the responsibility of any one agency alone.
> (3) Rehabilitation services for the chronic psychiatric population must go beyond those who have clear vocational goals (Rubin, 1980, p. 91).

In the 1980's, we began to see on a state-by-state basis the implementation of that NIMH/RSA Agreement of 1978. For example, in September of 1982, the Deputy Secretary for Mental Health for the Commonwealth of Pennsylvania sent out to mental health county administrators, base service unit directors, vocational rehabilitation facility directors, community residential rehabilitation providers, and mental health community program managers a concept paper and resources packet on developing effective vocational services for persons with chronic mental illness (Nelson, 1982). The materials had been previously used as part of the Office of Vocational Rehabilitation/Office of Mental Health (OVR-OMH) Interagency Agreement orientation and training sessions which had occurred that previous June and July. The Office of Mental Health and the Office of Vocational Rehabilitation had agreed to a series of nine premises in order to develop a model for shaping vocational rehabilitation services provided to the mentally ill residents of Pennsylvania. These premises are listed below as they so clearly illustrate the integration of a rehabilitation philosophy into the mental health world, if only, at that point in time, at a conceptual level.

Work is an important part of a normal life.

2. A properly designed work experience is an excellent environment for improving mental health.
3. Vocational rehabilitation services must be integrated into a comprehensive system of treatment and support services which can provide a smooth delivery of services as client needs change.
4. Vocational rehabilitation services should enable individuals to progress at the most efficient pace consistent with their abilities.
5. Clients should be trained in the most realistic setting which is compatible with their needs.
6. Generic resources (community college, vo-tech schools, trade schools, industry) should be used for training whenever possible.
7. Vocational rehabilitation services should be based on the strengths and needs of each individual.
8. A variety of opportunities for substantial, productive work needs to be available (competitive, sheltered and semi-competitive, full and part time).
9. The individual client must be involved in determining the goals and methodology used in his/her rehabilitation program (Nelson, 1982, p. 1).

Similar interagency agreements have been drawn up across the country in states such as Maryland, Idaho, California, Texas, Arizona, Oklahoma, Alabama, Washington, Michigan, and Wisconsin, to name a few. These agreements are in effect as we enter the decade of the 90s.

A Mental Health Perspective of Rehabilitation

Psychiatric rehabilitation has as its goal the reduction of social and vocational deficits which are often a sequel to and/or co-exist with a psychiatric illness. Psychiatric disorders are conceptualized as clinically significant behavioral or psychological syndromes or patterns that occur in an individual.

> In DSM-III-R each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (DSM-III-R, 1987, p. xxii).

Chronic psychiatric disorders have been further delimited by the severity of diagnosis and disability and the duration of illness (Minkoff, 1979). Goldman, Gattozzi and Taube (1981) offer the following detailed definition:

> The chronically mentally ill population encompasses persons who suffer certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders, and paranoid and other psychoses, plus other disorde

> that may become chronic) that erode or prevent the development of their functional capacities in relation to three or more primary aspects of daily living - personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning and recreation - and that erode or prevent the development of their economic self-sufficiency (p. 2).

Psychiatric treatment goals involve treating the person in the least restrictive setting, reducing mental disabilities, providing treatment in the community, making a wide range of services available and accessible to all persons who need them, and concentrating on the most severely or chronically disabled. While the focus of one (psychiatry) has been on symptom reduction and/or control, the focus of the other (rehabilitation) has been on community reintegration and attainment of the highest level of personal, social and vocational functioning. And yet, the two systems, psychiatric care and rehabilitation services, ultimately share the same clients/patients, similar processes, and resources for service delivery and congruent outcome goals.

From a mental health perspective, "rehabilitation" has been viewed historically as one phase or distinct unit of service in the continuum of comprehensive services required by persons with mental illness aimed at minimizing the negative consequences of their psychosocial disability. Thus, rehabilitative services, as a distinct and separate entity residing outside the mainstream of mental health services as traditionally defined, were available to these persons through a process of referral which occurred with irregularity, if at all, and in most cases were not inclusive of persons with severe psychiatric disabilities. The absence of rehabilitative services for individuals with chronic mental illness was the result of omission by the mental health system and commission by vocational rehabilitation agencies which saw the population of persons with severe psychiatric disabilities as problematic at the very least, and most certainly, as disruptive of the agencies' long-standing pride in their rehabilitation closure rates.

To illustrate this point with respect to mental health services, Rubin and Lotz (1977) surveyed mental health center administrators in Florida. Each was asked to rank in importance five services (psychotherapy, day treatment, residential, vocational rehabilitation and social club) for the adult chronic patient on a long-term and transitional basis. Vocational rehabilitation was ranked lowest on the list followed by social club. In another survey in 1982, conducted by the Office of Education and Regional Programming (OERP) at Western Psychiatric Institute and Clinic, the Department of Psychiatry at the University of Pittsburgh, mental health administrators from 27 counties in the Western Region of the State of Pennsylvania were asked to identify staff training needs in light of local service delivery needs. Not one of these administrators asked for training in the area of psychiatric rehabilitation for their respective staffs.

However, by the late 1980s these very same agency administrators were asking specifically for training in the area of psychiatric rehabilitation.

Thus, the purpose of this introductory chapter in a text devoted to the area of psychiatric rehabilitation will be: (1) to look at a definition of psychiatric rehabilitation in terms of four distinct frameworks and operational models which have or currently do exist; (2) to generally delineate the characteristics of the population of individuals with a chronic mental illness, their needs and deficits; (3) to review the need for rehabilitation services which exists among this population and in particular among the population of young adults who have a severe psychiatric disability; and (4) to update the definition of psychiatric rehabilitation as it exists interdependently in the worlds of rehabilitation and psychiatry.

REHABILITATION MODELS AND PSYCHIATRIC DISABILITIES

Traditional rehabilitation services for persons with psychiatric disabilities have historically developed out of three rather distinctive philosophies, each of which is separate from the world of traditional psychiatric care. These three philosophies then have been operationalized and have taken the form of a medical model, a work-focused model, and most recently, a competency-based or community model. Each of these models will now be discussed in light of their efficacy with regard to the population of individuals with severe psychiatric disabilities.

The Medical Model

The medical model has traditionally been tied to the area of the physically disabled with rehabilitation encompassing a broad range of medical treatment and restorative services. As part of the medical model rehabilitation approach, a vocational evaluation is prescribed just prior to the patient's discharge. This evaluation is conducted by vocational staff who are usually physically as well as psychologically unrelated to the rest of the multi-disciplinary team. Vocational recommendations are then "tacked on" to the rehabilitation plan despite a rehabilitation philosophy which espouses a "holistic" approach. Psychiatric patients have not fared well with such a practical model because the disability is not restored through external, mechanical or compensatory devices or through treatment procedures which occur in isolation from each other, such as the need for a hand splint, a whirlpool bath, or a speech therapy session in order to secure a successful rehabilitation outcome.

> When psychiatric clients enter rehabilitation settings whose programs are based on physical rehabilitation they create havoc because rehabilitation

> counselors attempt to apply methods designed for the physically disabled client and the psychiatric clients are usually unresponsive to those methods. Rehabilitation counselors tend to avoid the psychiatric client because of the client's bizarre or unpredictable behavior. To complicate matters, the client's diagnosis tells the rehabilitation counselor nothing about the client's deficits, whereas counselors can usually predict the deficits for clients with medical problems. Often the clients do not see themselves as disabled since their disability is not a visible physical one, and yet they may be helpless and hopeless in terms of gaining employment or learning to manage in the community (Krauss and Slavinsky, 1982, p. 240).

In addition, the time needed to build a relationship with a person with a psychiatric disability with low trust and weak ego boundaries is more extensive. He or she cannot be programmed in pre-established time frames for particular treatment modalities. Moreover, those skills most often intact with the client with a physical disability, such as interviewing skills, making career choices, putting together a resume and formulating relocation options, are most usually impaired or at times non-existent among those persons with a psychiatric disability. Interpersonal competence and the ability to present oneself in a positive light are areas likely to be negatively affected by the illness itself (Krauss and Slavinsky, 1982). Finally, closing a case as successfully rehabilitated, the goal of the vocational rehabilitation agency, seems at times virtually impossible with these individuals whose illness knows no predetermined discrete time intervals.

For those interested in a discussion of how such a model operates, Koltuv and Neff (1968) reviewed their experiences with the Institute for the Crippled and Disabled (ICD) in New York City, a facility that had served persons with physical disabilities for 40 some years. In a pilot project with the New York State Division of Vocational Rehabilitation over a 3-year period, the Institute served 100 individuals with a primary psychiatric disability ("process schizophrenic"(s), p. 254). Services were provided under the auspices of the sheltered workshop where extensive work evaluation occurred followed by training and/or placement recommendations. No data on follow-up of these clients were provided. One of the authors' comments, however, is germane to our discussion of this traditional physical-medicine rehabilitation approach with persons who have the psychiatric disabilities.

> In numerous instances, we have found that a client's behavior and work performance, in the workshop, TOWER, and the training classes were at considerable variance with interviewers' impressions of his current functioning and capabilities. Why this happens in unclear. It may be that behavioral specialists...have frames of reference that are inappropriate for making vocational assessments...Perhaps it is because professionals working in the vocational area are hampered by a lack of a general theory of work and

> by the incomplete understanding of the articulation between work ability and psychopathology (p. 259).

The Work Model

Vocationally oriented work-related models of rehabilitation have perhaps the longest history of all, dating back some seventy-odd years. These vocationally oriented programs were also the first to take in persons with psychiatric disabilities. Rehabilitation professionals such as Shiela Akabas of Columbia University's Social Welfare Center (1980) have written that rehabilitation has the most to offer clients when it is clear about its focus of vocational goals. Akabas purports that in accepting a competency-based model of rehabilitation, counselors are adopting an easy path rather than one which is in the best interests of these clients. "It allows the rehabilitation counselor to escape what is difficult - job placement - and to do what she/he may be trained for, namely, counseling" (p. 21). In criticizing the work of Grantham (1980), Akabas questions his search for a value base in rehabilitation, stating that it in fact exists, "...that work is desirable for human well-being and is a right which a society should insure to its population" (p. 21).

Earlier, Newman (1970) had also suggested that traditional methods of restoring socio-vocational functioning were inappropriate. He proposed a program wherein immediate job placement occurred at the start of the rehabilitation process and that after the client was employed, vocational behavior and shaping of appropriate work habits and interpersonal skills would be attempted. Newman viewed traditional training approaches as increasing the anxiety of former mental patients since they did not meet their immediate financial needs and that schools or training sites might actually provide a "shelter" to avoid confronting reality.

One of the most well known work models of rehabilitation for persons with psychiatric disabilities is the Fountain House program in New York City, after which programs such as Thresholds in Chicago and Fellowship House in Miami were modeled. Fountain House, through a Projects with Industry (PWI) grant, secured job placements for its residents with 50 small businesses and light industries in New York City for the purpose of providing on-the-job training. Over 150 individuals are served on a daily basis through this program and when and if the worker cannot fulfill his/her job duties on any given day, the agency staff member who has previously learned the job with the worker fills in the position, thus assuring the employer a continual and regular work force (Skelley, 1980 and Beard, Propst, & Malamud, 1982).

Olshansky (1980), long recognized for his work in the field of vocational rehabilitation and workshop settings, proposed a shift in perspective from psychiatry to rehabilitation if appropriate services were ever to be provided to the population of persons with chronic schizophrenia. He viewed the psychiatrist as having a very limited role in the ongoing delivery of services to these individuals. Specifically, he would serve as a consultant to the rehabilitation specialist and he would be the administrator of drugs. Chronic schizophrenia would be regarded as a behavior and management problem rather than an untreatable disease process. "But for this shift in perspective to be meaningful, 'work' would become the central activity within the rehabilitation process" (p. 128). For Olshansky, work prevents isolation in the chronic patient; it requires socialization and attention to external tasks and signals. It provides an opportunity for earning an income and gaining self-respect and also serves as a means of daily surveillance which identifies regression at an early stage while providing a regular routine for those who are incapable of any kind of autonomy or of organizing their time in an orderly way. Olshansky's answer to the availability of work opportunities is the creation of more sheltered workshops, many of which would be terminal as opposed to transitional in nature. Olshansky (1980) concluded:

> One problem associated with the suggested shift is that of persuading the psychiatrists to move back and rehabilitation specialists to move forward. It would probably be easier to persuade psychiatrists...than rehabilitation specialists...Ironically, he (the rehabilitation specialist) is still not committed to the rehabilitation perspective and to the value of work for the chronic schizophrenic. Like so many psychiatrists, he still thinks that given more time, he can counsel the chronic schizophrenic back to health and well-being (p. 129).

The most recent approach to the rehabilitation of persons with severe and disabling mental illness emanating from the work model is that of supported employment. This innovative rehabilitation technology, supported employment, was developed initially in response to the needs of persons with moderate and severe mental retardation. These individuals traditionally were limited to work activity programming, sheltered workshop placement, competitive placement with no job site training or follow-up, or failed to meet eligibility criteria for VR services in the first place (Revell, Wehman, & Arnold, 1984). The development of various supported work models for persons with developmental disabilities was pioneered by Bellamy in Oregon, Wehman in Virginia and Brown in Wisconsin. Supported employment is paid work, in a work environment with nondisabled workers, for persons with severe disabilities who cannot maintain employment without ongoing assistance from a service provider responsible for employment support. Supported employment includes the provision of: 1) intensive initial training of persons with a severe handicap generally done on the work site; 2) continuing intervention to assist the individual in accomplishing specific work tasks to sustain employment; and 3) retraining to allow persons with severe handicaps to remain employed in the original job or to transfer to another job (Report from the Study Group on Supported Employment, 1985).

While supported employment was first authorized in 1984 under the Developmental Disabilities Assistance and Bill of Rights Act [P.L. 91-517, as amended, Section 102 (E) and (F)], it had not been officially mandated in Rehabilitation legislation until the Rehabilitation Act Amendments of 1986 [P.L. 99-506; Section 7 (18)]. State project demonstration grants in the area of supported employment were awarded by the Rehabilitation Services Administration, U.S. Department of Education, beginning in 1985, under the Special Projects and Demonstration discretionary grant category as authorized under Section 311 (a) (1) of the Rehabilitation Act (50 Federal Register 25407, Section 373.14 (a), June 18, 1985). Under the Rehabilitation Act Amendments of 1986, which authorized the supported employment formula grant program under Title VI, Part C of the Act, supported employment is defined and its relationship to most individuals with chronic mental illness addressed in particular.

> (18) The term "supported employment" means competitive work in integrated work settings--(A) for individuals with severe handicaps for whom competitive employment has not traditionally occurred or (B) for individuals for whom competitive employment has been interrupted or intermittent as a result of a severe disability, and who because of their handicap, need ongoing support services to perform such work. Such term includes transitional employment for individuals with chronic mental illness. For the purposes of the Act, supported employment as defined in this paragraph may be considered as acceptable outcome for employability (p.6).

The recognition that employment and job retention strategies, and in particular the use of a supported employment model, with persons who have a chronic mental illness are somehow unique and that they require more linkages brought about the convening of a state-of-the-art (SOTA) conference in Washington, DC, in March of 1987. It was the privilege of this author to participate in the SOTA conference. It became clear that major issues (implementation strategies, particular needs of persons with long term mental illness, social welfare disincentives, trained personnel) were in need of further study if policy-level decisions and regulatory standards were to be relevant and meaningful with this particular population of persons "traditionally not in the workforce" (p. 1 Monograph: Supported Employment for Chronically Mentally Ill Individuals, 1987). These issues will most likely be addressed with the reauthorization of the Rehabilitation Act.

The Competence Model

The competence or community model of psychiatric rehabilitation follows principles which were first summarized by Lamb (1977), appear to follow early conceptualizations of rehabilitation which focused on the whole person (Whitehouse, 1960; Wright, 1960), and later were modified by Anthony (1980). Lamb's model stresses the social and emotional competence of the individual and the important role that environment plays in the process. The goal of rehabilitation under this model is the development of the individual to the point where he/she can cope with a residual disability while achieving his/her maximum psychological and vocational potential. Work is seen as something which can be enjoined or from which one can be disengaged. It is essentially replaced in the hierarchy of rehabilitation values by support systems in the environment which speak to the whole of the individual. Lamb's (1977) ten principles are as follows:

1. Rehabilitation should be primarily in the community.
2. The rehabilitation plan needs to be comprehensive, including social and vocational rehabilitation, individual or group psychotherapy, psychoactive drugs if needed, financial assistance and the provision of a supportive living arrangement if required.
3. A high priority should be given to learning "in vivo."
4. The goal is to focus on the healthy personality.
5. The focus should be reality factors rather than intrapsychic phenomena, and on changing behavior rather than changing basic character structure.
6. In working with chronic patients, high but realistic expectations must be maintained so patients can strive to attain their full social and vocational potential.
7. Rehabilitation efforts should be aimed at giving the patient a sense of mastery over his internal drives, his symptoms, and the demands of his environment.
8. An "institutional alliance" develops among psychiatric patients in which they relate more to the institution than to an individual.
9. Relatives are more to be relied upon as primary care agents.
10. Rehabilitation goals must be clearly defined in each phase of rehabilitation (Grantham, 1980, pp. 2-3).

The overall goal of psychiatric rehabilitation for Lamb (1977) is "to expand the remaining well part of the person instead of to remove or cure pathology" (p. 3). It is with this particular statement that the work of Anthony (1979) seems most in agreement. For Anthony, it is the lack of interpersonal social skills and work-related skills which must be repaired regardless of the psychiatric disability involved. He bases this conclusion on the results of his extensive review of the literature which indicates that:

1. Successful adjustment to a work environment does not correlate significantly with adjustment to living or learning environments.
2. Clients often lose their jobs, not due to an inability to perform tasks, but because of skill deficits in emotional and interpersonal functioning.
3. Clients who lose their jobs often don't possess the skills to get another one and either don't try to find one or return to their rehabilitation for help.
4. There is no relationship between hospital based work treatment and competitive employment.
5. Thirty to fifty percent of discharged patients obtain employment and only twenty-five percent retain it (p. 129).

What then follows is Anthony's approach to skill training under the competence model. The "empathy-trained" counselor proceeds to utilize a rehabilitation process based on work adjustment training, career counseling, and career placement, three essential components to the vocational rehabilitation process. Since this model also recognizes that not all psychiatric disabilities will be amenable to rehabilitation through improved skill behavior, the counselor also looks to the environment in order to evaluate whether it can be adapted to accommodate the client's deficits. Anthony, much like Olshansky, would have us alter the knowledge base and technical proficiency of the rehabilitation specialist (but obviously in different areas) if the rehabilitation process is to be successful with the psychiatrically disabled population. He does not particularly concern himself with the timing or location of the process as long as the basic ingredients as he sees them are delivered. Anthony's competency model, then, in many respects is a psychosocial revision of Olshansky's work model. Thus rehabilitation strategies and outcome goals are updated in light of the 1978 amendments to the Rehabilitation Act, which extended vocational rehabilitation's responsibility to those without a clear potential for independent competitive employment.

The Comprehensive Center Model

The fourth model of psychiatric rehabilitation which will be discussed was alluded to by Grantham (1980) when he reviewed the community support program model and its relationship to rehabilitation and mental health. "It is a program which provides linkages among agencies, focuses on problems in living rather than personality restructuring, is comprehensive and provides for easy access, relies on the helping skills of people rather than professional labels, and makes available opportunities for consumers and other citizens to have input" (p. 13). Thus programs such as Fellowship House in Miami (Rubin, 1980) and Thresholds in Chicago (Dincin and Witheridge, 1982) have been des[illegible]d as fulfilling the CSP Mandate.

Fellowship House is viewed as the "core service agency" which is prescribed by the NIMH guidelines. The core service agency is committed to helping people with severe psychiatric disabilities improve their lives whether by the direct support services it provides or through a series of integrative functions which link the severely disabled person to the existing community or, when necessary, through the establishment of a therapeutic community milieu if none exists. The ten components of such a core service agency (Turner and TenHoor, 1978) include: identification of the population at risk; assistance in entitlement applications; crisis stabilization in the least restrictive setting with hospitalization available when other options are unavailable; psychosocial rehabilitation services; supportive services of indefinite duration; medical and mental health care; backup support to families, friends and community members; involvement of concerned community members in planning, housing and work opportunities; protection of client rights and case management.

While Dincin and Witheridge (1982) do not label Thresholds as a core service agency they do describe the agency as a comprehensive psychiatric rehabilitation center which provides reality-based treatment for discharged patients at high risk for rehospitalization. In an effort to evaluate the effectiveness of such a comprehensive rehabilitation program, a total of 102 clients were randomly assigned at intake to either a full-time comprehensive program or a part-time supportive treatment program at a different location. Comprehensive treatment was seen to include: individual casework, vocational rehabilitation, social rehabilitation, residential facilities, academic programming and prevention of rehospitalization. The supportive treatment program relied almost exclusively on rehabilitative services and facilities available in the surrounding community. The comprehensive treatment program was staffed with 30 full-time workers and other part-time and volunteer help while the supportive treatment program had two part-time staff and several trainees and volunteers. A psychiatrist was available to the supportive program every two weeks to meet with clients to prescribe and monitor the use of psychotropic medication. In the comprehensive treatment program the consulting psychiatrist also co-led discussion groups with a nurse around issues of noncompliance and medication. After nine months, 14% of the comprehensive treatment group subjects had been rehospitalized in contrast to 44% in the supportive treatment group. However, it should be noted that all rehospitalized subjects had histories of more frequent admissions than did the subjects who were not rehospitalized. In terms of employment, only 39% of either group were gainfully employed either part-time or full-time at the time of follow-up, and clients assigned to the supportive treatment group actually earned on an average more than did the comprehensive treatment group (Bond, Dincin, Setze, and Witheridge, 1984).

As a final outcome, Dincin and Witheridge (1982) reported a significant cost reduction through use of the comprehensive program, which while 11 times the cost of the supportive treatment, amounted to only two-thirds of the total expenditure of public funds when inpatient hospital days were entered into the cost-benefit analysis.

Based on their studies at Thresholds, the authors (Bond et al., 1984) concluded:

> Vocational is one of the most poorly understood aspects of psychosocial rehabilitation. The paradigm used for physical disabilities (evaluation-training-placement) is not appropriate for most of the long-term mentally ill. For one thing, psychiatric clients do not ordinarily require the specific sorts of retraining that those with physical or cognitive disabilities need (Newman, 1970). Moreover, while most disabilities can be said to be "stabilized" (in the sense the condition is unlikely to change in the short term), mental illness is less predictable. Thus, evaluation, as conducted in traditional vocational rehabilitation settings, is also less meaningful. Moreover, work limitations are not easily detected through standardized tests. For such reasons, psychosocial rehabilitation emphasizes the shaping of good work habits and attitudes (which many psychiatric clients lack), and de-emphasizes client assessment and training for particular vocations. However, despite the emphasis on employment at Thresholds, graduates have a far from impressive employment rate. It is time to examine why this is true and to ask whether the Fountain House Model has been "oversold." Unlike rehospitalization statistics, employment rates are rarely reported (Anthony et al., 1978). The methods for reporting employment rates vary drastically among studies. We can offer a number of possible explanations for the Thresholds vocational statistics: that the economy has been in recession, that the value of the vocational program rests not with its rate of employment success, but with its ability to improve social functioning, raise self-esteem, and structure daily activities; or that the modest employment rates which we have reported are nonetheless above the base rates reported for the general psychiatric population. Others, such as Wilder (1976), have concluded that the goal of competitive employment is beyond the grasp of a large proportion of the long-term mentally ill population and that we should therefore redirect our efforts toward designing permanent sheltered or semi-sheltered employment programs tailored to the needs of the psychiatric population. Where we disagree with Wilder (1976) is in his implication that transitional employment approaches are unnecessary, since clients who eventually find competitive employment would succeed in any case. A wide range of vocational programming, including transitional employment, sheltered employment, and skill training (for uneducated and unskilled) would probably be ideal (pp. 19-20).

Both of these programs, however, lie in the domain of the rehabilitation world as opposed to the world of mental health. More specifically, they are not based in a psychiatric treatment service or community mental health center but are rather extensions of the psycho-social rehabilitation model. However, it seems rather clear at this point in time, particularly in view of the national commitment of NIMH and the RSA to provide services to persons with long term and severe mental illness, that the mental health community will become more immediately involved in the rehabilitation process. Grantham (1980) in his review of the impact of community support programs wrote:

> Given the the co-mingling of service populations, problems addressed, and services rendered, it is conceivable that rehabilitation for the mentally ill could become the responsibility of the mental health system. It would appear to be no real problem for mental health to add a role which functions around vocational counseling, placement and follow through services. The list of services detailed by the CSP...leaves this possibility wide open....Efficiency may dictate that the best prepared agency assume program control. In the initial agreements on CSP, control was yielded to NIMH (p. 14).

Just as the need for periodic rehospitalization has been recognized as a legitimate need for certain individuals who are chronically psychiatrically disabled (Mosher and Keith, 1979; Bachrach, 1979) so the issue of work as an end goal in the rehabilitation process has been opened to question. "Rehabilitation of persons with mental disabilities in the final analysis will be defined as a competence in problems-of-living issue. It will be geared toward determining whether work contributes to a healthy adjustment and where indicated, assisting in the achievement of appropriate work behaviors" (Grantham, 1980, p. 14).

An Integrative Model

The final model, and the one with which the authors are most familiar, functions as part of a large comprehensive psychiatric service and utilizes an altered definition of successful outcome in rehabilitation for persons with chronic mental disabilities. This definition takes into account the issues of periodic rehospitalization while addressing the need for alternatives to competitive employment with this population (Katz-Garris, McCue, Garris and Herring, 1983). The Department of Neuropsychological Assessment and Psychiatric Rehabilitation was established within the Department of Psychiatry at the University of Pittsburgh, School of Medicine, Western Psychiatric Institute and Clinic in 1977. The Department's purpose is to facilitate community reintegration of the patient population so that these individuals might achieve their potential for independent living, which may or may not include employment and the need for periodic rehospitalization. The philosophy of the program is goal-oriented, purposive, functional, and educational; and, therefore, assessment and therapeutic services have as their focus the enhancement of functional skills. Programming includes comprehensive assessment services, prevocational evaluation and training, career planning and counseling, and supportive group experience in conjunction with the patient's primary treatment program. All rehabilitation focused activities are initiated and implemented in light of two basic assumptions: (1) that all treatment/rehabilitation services are collaborative endeavors between the primary treating clinician, the rehabilitation counselor, and the patient; and (2) that timing of rehabilitation-related programming is pre-determined in order to insure synchronized or simultaneous undertakings. Collaboration is both formal and informal. The rehabilitation counselor takes an active role in maintaining lines of communication between the primary clinician and all other treatment and rehabilitative services, with primary responsibility for linkages with vocational rehabilitation services in the community. The following diagram (Table I) illustrates the kinds of treatment/rehabilitative services offered throughout the course of the psychiatric treatment program.

In an effort to determine the effectiveness of its rehabilitation-oriented service which functioned as a component of psychiatric services offered by a large, urban, university-based hospital, the Department conducted a follow-up study on 277 patients out of a total of 342 who had received such services, two and one-half years prior to follow-up.

> Regarding the effectiveness of services provided by the Department of Psychiatric Rehabilitation in relation to the program's overall goal of community reintegration, three separate outcome measures were assessed. Relative to the first outcome measure, productive activity, 43.3% of the sample were categorized as productively engaged and 56.7% were not active. The second outcome measure, quality of community adjustment, utilized a self-rating scale measuring the patients' level of satisfaction with their adjustment to the community. These data revealed that 65.9% of the sample considered themselves satisfied, while 34.1% were not satisfied. Turning to the final outcome measure, amount of community involvement, 41.1% of the sample were rated as having been involved in the community, while 58.8% were not involved or only minimally involved (Katz-Garris, McCue, Garris and Herring, 1983, p. 333).

In addition, certain critical variables (age, sex, and educational background) were found to be significantly related to the outcome criteria. And perhaps as important for the field of psychiatric rehabilitation, this study demonstrated the utility of nontraditional outcome measures in evaluating the effectiveness of

TABLE I

A MODEL FOR THE DELIVERY OF PSYCHIATRIC REHABILITATION SERVICES IN A MENTAL HEALTH SETTING

ACUTE TREATMENT PHASE

Acute Hospital Stay 18-22 Days

TREATMENT ⟷ **REHABILITATION**

TREATMENT

- Medication
- Medical Care
- Individual Psychotherapy
- Therapeutic Milieu
- Group Activities Including the Expressive Arts
- Family Education

REHABILITATION

- Vocational & Educational History
- Assessment of Basic Academic Skills
- Assessment of Psychological and Neuropsychological Parameters
- Assessment of Vocational Interests, Values, Aptitudes

SUBACUTE TREATMENT PHASE

Outpatient Therapy 4 - 12 Months

TREATMENT ⟷ **REHABILITATION**

TREATMENT

- Intensive Insight Oriented
- Behaviorally Oriented
- Supportive
- Medication Monitoring Only or in Conjunction with One or More of the Above
- Family Education and Consultation

REHABILITATION

- Review of Assessment Findings
- Joint Goal Planning
- Job Seeking Skills Training,
- Resume Preparation & Job Interviewing
- Work Adjustment Group
- Vocationally Oriented Career Counseling
- Participation in Work Training Internship
- Referral to VR Services for Placement and/or Training

Partial Hospitalization 2 months - Ongoing

TREATMENT ⟷ **REHABILITATION**

TREATMENT

- Medication Group
- Expressive Arts Groups
- Current Events Groups
- ADL Groups
- Supportive Individual Counseling
- Medical Maintenance
- Medication Monitoring

REHABILITATION

- Pre-Vocational Skills Group
- Individual Vocational Career Counseling
- Partial Participation in Work Training Internship
- Ongoing Support for Work Evaluation Placement
- Linkages with VR, Welfare
- Tutoring for Remediating Academic Deficits
- Exploration of Community Support Systems
- Exploration of Volunteer Activities

IN REMISSION TREATMENT PHASE

Outpatient Status - Ongoing

TREATMENT ⟷ **REHABILITATION (Post Employment Service)**

TREATMENT

- Supportive
- Medication Monitoring
- Family Support
- Prevention of Decompensation or Rehospitalization If and When Necessary
- Link-up with Other Agencies

REHABILITATION (Post Employment Service)

- Follow-up on Training or Placement Status with VR Client Placement
- Reality Oriented Counseling Re: Work Adjustment Problems
- Problem Solving, Peer Support Groups
- Facilitating Entry into Ongoing Community Activities
- Crisis Intervention Re: Day Care Needs, Housing, Health Benefits
- Assisting with Applications for Entitlement Programs
- Follow-up on Volunteer Activities
- Supported Employment

services. Such outcome measures are more in keeping with the broadened mandates of rehabilitation legislation and policies while directly responding to the NIMH/RSA Cooperative Agreement's goals and guidelines.

REHABILITATION NEEDS OF PERSONS WITH PSYCHIATRIC DISABILITIES

Thus far, we have reviewed the historical process which has brought the fields of psychiatry and more broadly mental health and rehabilitation to a common meeting ground in the area of services to persons with chronic mental illness. In addition, we have reviewed in some detail, the often disparate underlying philosophies of rehabilitation--medical, vocational and competency-based--which have also converged in meeting the needs of this population. It is left for us now to review the characteristics of this population, their specific needs and those special issues which emerge for the practitioner regarding the provision of services for persons with psychiatric disabilities in order to meet their special needs.

Characteristics of the Population

Roughly speaking, persons with chronic mental illness are comprised of three groups of individuals: deinstitutionalized persons, "revolving door" persons who go in and out of hospitals, and individuals with chronic disability who are not hospitalized (Cutler, 1981). Bachrach (1979) further differentiated the population by location and distinguished between five separate subgroups which represented "fallout from the deinstitutionalization movement" (p. 388). According to Bachrach these individuals once constituted the totality of persons residing in state hospitals but now they are: (1) patients released from the hospital; (2) persons who have never been hospitalized, but at an earlier time would have been; (3) old long-stay residents of the hospital who have not been released; (4) recent admissions of short-stay patients; and finally (5) new long-stay patients "...a build-up of long-term residents from among recent admissions who are unlikely to be considered good risks for community care and probably will not be discharged" (p. 388).

Lamb (1979) studied a group of 101 residents of board-and-care home facilities in the state of California which had developed in the community to fill the vacuum created by the deinstitutionalization of California's state hospital system. He sought to examine the characteristics of this population and how these residential facilities might have replaced the state hospital in terms of patient needs. The median age of the population was 39 years, with a range of 22 to 63 years. There were nearly twice as many men as women; 92% of the group had been previously diagnosed as psychotic and had been hospitalized from 0 to 28 years; and 42% of the population had resided in the board-and-care facility for 5 years or more. Only a little more than a third of this population had contact with a mental health professional and this was generally the psychiatrist who visited the facility for medication management. Thirty-one percent of the group had been hospitalized during the previous year while 32% of the sample "exhibited severe overt major psychopathology" (p. 130). Sixty percent of the residents had received community vocational rehabilitation services, but only 12 of the 61 persons who had received services were still involved; one in a competitive employment setting, three in a training program and eight in sheltered workshops. One-fourth of the residents who had received vocational rehabilitation services reported that they had been unable to do the work required in the sheltered workshop or were fearful that they could not. With an additional 10% it appeared that the vocational counselor had overestimated their strengths and had placed these individuals in training programs beyond their capabilities. "In most cases, the vocational counselor had not been part of a therapeutic team that included a primary therapist or case manager" (Lamb, 1979, p. 133). Finally, 52% of the residents had no goals to change anything in their lives, and in those 30 years of age and older with a lifetime history of six months of hospitalization or more, the lack of motivation was even greater. In discussing the issue of motivation and goals Lamb (1979) comments:

> Perhaps some would benefit from better drug management. And surely this group should be the object of a concentrated effort at outreach from community agencies to provide individual and group psychotherapy and social and vocational rehabilitation. At the same time, it must also be recognized that there are persons in board-and-care homes just as there are persons in society generally for whom we do not have the answers with regard to making their lives happy, anxiety-free, and meaningful (p. 133).

In 1980, a NIMH-sponsored survey was designed to study a random sample of 1,471 chronically mentally disabled adults being served by community support systems (programs) in terms of demographic characteristics, clinical histories, and level of functioning (Tessler, Bernstein, Rosen and Goldman, 1982). The median age of the group was 42 years, with the proportion of men (47%) and women (53%) nearly equal. While one-third of the group were high school graduates, only 25.9% were employed at the time of the survey, and of those only 41.8% were employed in competitive settings. The remainder were working in "sheltered workshops (37.1%), in paid transitional employment programs (11.2%), in unpaid work training programs (8.7%), or as volunteers (1.2%)" (p. 209). Of those surveyed, 92.3% had been hospitalized for psychiatric care at some point in time with a median admission rate of 3.1. In terms of current functioning, the most problematic skill deficits were in managing transportation [illegible] money, adhering to medication regimens, meal preparation, verbalizing needs and securing appropriate services. Others suffered from obesity, undernourishment, medication side-effects and impaired motor control. "Contrary to the popular conceptions, the vast majority of CSP clients did not have behavioral problems that threatened or violated important social norms..." (Tessler, Bernstein, Rosen and Goldman, 1982, p. 209). In concluding their findings these authors wrote:

> This article has addressed three interrelated questions: Is the CSP serving a chronically mentally ill population? Are the ten components of a community support system actually in use? And, finally, are the neediest individuals receiving services? In each case, the preliminary answer is a qualified yes (p. 211).

While a non-federally funded CSP, a group of agencies established themselves as a core service committee (agency) under the NIMH guidelines for community support systems in the Oakland section of the City of Pittsburgh in the state of Pennsylvania. This community has a sizable resident population of persons with chronic mental illness due in part to the availability of Western Psychiatric Institute and Clinic, various transitional living facilities, and the availability of affordable housing in the area. The general needs of this group have been documented in a variety of studies and reports which have been conducted throughout the Western Region of Pennsylvania over the past several years, and all have underscored the need for additional and innovative support programs for persons with chronic mental illness who reside in the community. A major element of the comprehensive services needed for this population includes innovative approaches to "linking" services, which is a particularly complex process because of the variety of administrative agencies, both public and private, state and local, which are involved in service delivery in the state.

As part of its CSP function, the committee identified a target population to be addressed by the NIMH guidelines which have been previously discussed in this chapter. This population consisted of 250 former patients who were being served by one or more of the participating agencies. Most of the patients (75%) were female while 42% of them were between the ages of 55 and 69. Seventy-four percent were unemployed and those who did work did so in sheltered workshops or vocational rehabilitation centers. Of those discharged from hospital settings, 40% had more than ten rehospitalizations, while only 26% had not been rehospitalized during their community tenure. The committee concluded that these post-hospital patients in general: (1) had very poor self-concepts and showed dependency needs; (2) lacked the motivation or capability to make contact with sources of assistance and support; (3) were unable to meet basic living needs and often lacked the resources to secure housing, adequate food and clothing; (4) had a difficult time finding and keeping jobs; (5) had difficulty using leisure time in a satisfying or rewarding manner; (6) were unable to establish and maintain social and personal relationships so that the natural folk-support systems were inadequate; and (7) most needed sustained contact with the mental health and medical systems for ongoing treatment and medication (The Development of an OAKLAND Community Support System, 1983).

Thus, it becomes clear that the population nationally surveyed, as well as that specifically defined in California and Pennsylvania, share common characteristics of a chronic condition. Investigators such as Summers (1981) and Krauss and Slavinsky (1982) suggest that chronicity may have more to do with the persistence of social and vocational deficit than the continuance of systems and that the essential feature of chronicity may be functional deficit. While specifically addressing that population having been diagnosed as schizophrenic, Summers writes: "The residual deficit of the schizophrenic lies primarily in the area of social and vocational functioning, rather than psychotic symptoms" (p. 712).

Support for this contention can be found in the review by Gunderson and Mosher (1975) of the cost of schizophrenia in the United States. A conservative estimate of such costs on an annual basis amounted to $11.6 billion. Of this total amount, only one-fifth can be derived from the direct delivery of services, while the remaining four-fifths is the result of the loss of productivity among this population. With respect to readmission rates, Gunderson and Mosher (1975) note that despite the doubled utilization of outpatient care by schizophrenic patients between 1971 and 1973, "rehospitalization rates do not appear to have been affected" (p. 904). "Thus it may not be the lack of outpatient facilities so much as their failure to provide meaningful treatment for (persons with schizophrenia) that account for their lack of impact on readmission rates (p.904)." In addressing ways in which the cost from loss of productivity among this population might be diminished, Gunderson and Mosher point to: (1) the increased use of alternative housing; (2) greater emphasis on vocational rehabilitation "during all phases of treatment and smoother reentry into working situations from residential care" (p. 905); and (3) increased governmental, both federal and local, efforts to "support and coordinate rehabilitative services specifically designed for mental patients" (p. 905).

Needs and Deficits

Krauss and Slavinsky (1982), after reviewing the sociologist Strauss's comprehensive model for the analysis of the needs of individuals with chronic mental illness, which includes: prevention and management of medical crises; control of symptoms; regimens of carrying-out treatments; prevention of isolation; adjustment to changes in the course of the disease; normalizing life-style and interactions with others; and funding, conclude that deficiencies emerge that would have "serious implications for the planning and implementing of care for the psychiatric chronically ill" (p. 38).

> The severity of the illness, the long-range nature of the disorder, the lack of effective technology to treat the disorder, the extreme stigma, and the extent of the social disability involved all combine to create a unique human experience with a unique set of problems (p. 46).

Cutler (1981) has defined the needs of persons with chronic mental illness in terms of the environmental spheres in which five functional need-areas are carried out. These five functional areas are components of a service delivery system which deals with (1) personal needs; (2) social needs; (3) productive activities; (4) recreational needs and (5) the ability to get services. Essential to each component is the provision of case management. "The goal of case management is to assure that long-term patients are enmeshed in a social support system that can be designed in the least restrictive environment" (p. 349). Unlike the non-psychiatrically disabled chronic population, those with a mental disability often present with a wide variety of bizarre and disturbing symptoms and behaviors which not only impinge on the individual but also cause a negative reaction in those with whom they associate. Coping with the basic necessities of daily living is a major undertaking. When one adds other basic life needs such as work, leisure-time activities, and rewarding social interactions, it is near impossible for the patient who is chronically ill to fulfill such needs without formal assistance.

> In short, chronic patients lack what Mary Ann Test...has called "network cement." They simply do not stick themselves to other people. On the contrary, they have a tendency to avoid others except for those who share the same living quarters. It is important that those who are designated to make up a support services network for the chronic patient be highly attuned to this fact (Cutler, 1981, p. 349).

With respect to the area of productive activities in particular, in our society, having a meaning in life is most often determined by what one does with his/her life. In an existential sense, "the what I am" often defines the "who I am." Where I am in the continuum of productivity is not so much an issue as is the fact of being within that continuum in the first place. As the reader may recall being productively engaged was one of the outcome variables used in the Katz-Garris, et al. psychiatric rehabilitation outcome study which expanded upon the traditional criteria, recidivism and employment. Investigators such as Turner and

Gartell (1978) in their study of the social factors involved in psychiatric outcome point out that, although there is evidence for an important interdependence between competence [social competence is defined as an acquired capacity for socially effective behavior and "corresponds to the individuals' level of psychosocial development"...and..."ability to meet expectations set by society" (Phillips, 1966, p. 47)] and type of severity of psychopathology, the two are separable in terms of their relationships to outcome. They would have us conclude, moreover, that "the enhancement of competence as a critical and distinct therapeutic goal... deserves as much attention in the treatment process as do the dynamics underlying symptom expression" (p. 379). Meaningful activity, whether it be paid work, volunteer experiences, training, etc., is an in vivo arena for the development of social competence and as such is an essential ingredient of the psychiatric rehabilitation process from the perspective of mental health as well as from the perspective of rehabilitation. It is here again that we see the convergence as well as the interdependence of the two once separate worlds.

Schumacher (1980), in his comprehensive review of significant studies which have dealt with the coordination of services for persons with mental illness, has extracted certain critical variables in the psychosocial adjustment of persons with long-term mental illness. In reviewing the area of productive activities and most specifically work, Schumacher comments that long-term follow-up and repeated hospitalizations may remain an important or continuing feature of these individuals and that rehabilitation can only be planned and carried out with the expectation of giving long-term support, but that "(R)ehabilitation programs alone may not be the long-term answer to the severely mentally ill" (p. 53).

Bachrach (1979) took Schumacher's statement to its logical conclusion when she wrote that reality is absolutely essential in the planning of services for persons with chronic mental illness. She suggested six dimensions to the planning process which include: (1) the need for mental hospitals; (2) the importance of precise planning goals; (3) the unique service needs of the chronically mentally ill; (4) the need for interagency planning; (5) the importance of a functioning and sensitive patient tracking system; and (6) an appreciation of the attitudinal structure within which mental health services are delivered. The need for mental hospitals is "consistent with an understanding of the nature of chronicity that holds that for some patients relapse is inevitable and is best dealt with in hospital settings" (p. 389). But just as important and in keeping with the purpose of this chapter:

> The uniqueness of planning for the chronically mentally ill lies in the fact that those supportive human services that are traditionally considered to be domain of social services or rehabilitation, and not of medicine, play a

> somewhat different role. Provision of these supplementary services must be understood as being part of the basic treatment regimen.
>
> In short, the so-called medical model and the human services model must merge for the successful care of the chronically mentally ill (Bachrach, 1979, p. 390).

Bachrach's work has been updated and her hypotheses empirically tested in the recent work by Bond and Boyer (1988). These authors analyzed the outcome of some 21 programs reported in the literature between the years of 1963 and 1986 which utilized a controlled or quasi-controlled design in the measurement of vocational rehabilitation outcomes. The authors concluded:

> Do psychiatric vocational programs help clients achieve competitive employment? The answer is complicated by the diverse outcome measures used. If the criterion is the competitive employment rate at the end of the follow-up period, then only two studies yielded significant results. If the criterion is job starts in competitive employment, then four other studies might qualify. Compiling the summary judgments given...only four of twenty-one studies showed an overall advantage to experimental subjects on competitive employment. Moreover these four studies each have methodological limitations. The general conclusion is that none of the approaches...have demonstrated efficacy in helping clients achieve and maintain competitive employment over any sustained period of time.
>
> In contrast, when the criterion was paid employment (including transitional and sheltered employment), eight of ten studies indicate that when clients are given intensive support and are placed in jobs that are not too demanding, they often function at a level beyond usual expectations. Both intensive support and positive expectations that clients can succeed appear to be important elements (pp. 252-253).

The Young Adult Chronic Patient: A Special Need

Before concluding this final section on the rehabilitation needs of persons with psychiatric disabilities, it is important to recognize the existence of, as well as the special needs of, an increasingly growing population of young adult patients with chronic mental illness. They can be characterized generally by three distinguishing features: (1) that for the most part since the onset of their illnesses, they have lived in an era of deinstitutionalization (Caton, 1981); (2) that they manifest, despite a variety of symptom profiles, severe difficulties in social functioning; and (3) that they tend to use mental health services extensively and inappropriately, "in ways that drain the time and energy of clinicians yet do not conform to viable treatment plans" (Pepper, Kirshner and Ryglewicz, 1981, p. 463).

Bachrach (1982) has done an excellent job of reviewing the literature with respect to the young adult with chronic mental illness in which she highlights patient clinical characteristics such as their mobility, their inability to handle stress, their use of psychiatric services in a revolving-door fashion, their inability or unwillingness to hook-up with a system of care, their hostility, belligerence toward and demanding manipulative behavior toward therapeutic staff, their use of street drugs, their low tolerance for frustration, and their impulsive behaviors which often result in encounters with the law. Schwartz and Goldfinger (1981) go so far as to say that it is not their needs which distinguish them from other persons with chronic mental illness, but rather problems which result from their style of interaction with existing community-based services. "At presen., these 'new chronic patients' are discontented, disengaged, and difficult for all who come in contact with them" (p. 474).

Pepper, Kirshner and Ryglewicz (1981) have reported on their efforts at the Rockland County (New York) Community Mental Health Center to study this population and the services offered them. Among the variety of programs were a crisis service, a sheltered workshop, a residential program, an acute day treatment program, and a growth advancement (social) program. While preliminary findings of their work were based on clinical judgments of involved staff, it is not surprising that the need for residential programs was seen as one of the most glaring deficits in the service delivery package.

While the Rockland study (Pepper, Kirshner and Ryglewicz, 1981) reported clinical estimates of over one-third of their study population in need of long-term hospitalization, Bachrach (1982) posits that a series of eight program principles shared by successful model programs for persons with chronic mental illness appear to hold for the young adult patient as well. She discusses each of these components in detail for the interested reader, but we shall only list them in this discussion for our present purposes as her presentation needs no further elaboration. The eight principles include: (1) a full range of services including psychiatric, medical, rehabilitative, vocational, social and residential programs; (2) the coordination and integration of resources; (3) individualized treatment including more creative vocational programs; (4) specially trained staff who can bridge the gap between the hospital and community and who can work flexibly and integratively in diverse service settings; (5) flexible programs which take into account follow-up mechanisms and family involvement; (6) hospital services as well as nontraditional and noninstitutional settings; (7) cultural relevance and compatibility; and (8) top priority assignment in the services delivery system not encumbered by limiting external system constraints such as eligibility for care management services which is tied to previous extended or significant periodic hospitalization.

CONCLUSION

In conclusion, psychiatric rehabilitation had been frequently viewed as a component in the continuum of comprehensive services required by hospitalized persons with mental illness to facilitate their re-entry into the community (Menuck, 1978; Schulman, 1980). However, the concept of psychiatric rehabilitation has taken on a broader meaning in the 1980's as a consequence of the era of deinstitutionalization, the consumer movement, the rights of the handicapped legislation and litigation, the economic recession of preceding years, and the continuing growth of technology both within and without the field of human services. Psychiatric rehabilitation is the comprehensive continuum of services, which includes medical, social, psychological, vocational, recreational, residential, and inter-agency and linkage services. Psychiatric rehabilitation can no longer be seen as strictly vocational in nature and thus somehow separate from the treatment process. Psychiatric rehabilitation is the treatment process, in the broadest sense of the word, since its underlying philosophical base is grounded in the concept of the whole person, the holistic approach. Its outcome is restoration and the restitution of dignity (Oberman, 1965). Such overwhelming and broadly defined goals can only be achieved if the process is viewed similarly.

This chapter title has used the word "interdependence" in order that the discrete components of psychiatric rehabilitation might be more clearly understood. While there are those who will continue to emphasize specific programmatic initiatives at the expense of others, equally legitimate, in the implementation of the process, it becomes exceedingly clear that particularly with respect to the needs of persons with chronic psychiatric disabilities, this pre-determined, compartmentalized process is not now functional, if it ever was. The worlds of psychiatry and rehabilitation share an uneven track record, at best, when one considers these persons with chronic mental illness whose numbers have not diminished. In light of the overwhelming costs to our nation, both financially and in terms of human waste, a mutually interactive and reciprocal process in the field of psychiatric rehabilitation among professionals, care givers, agency administrators and legislators is essential.

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Chapter XI

ROLE OF THE REHABILITATION PRACTITIONER

LYNDA J. KATZ, PH. D.

INTRODUCTION

In this final chapter we will discuss the role of the rehabilitation practitioner, the ways in which this role may be affected by as well as effective with the population of persons with psychiatric disabilities. In so doing it will be important to ask the questions: What can be expected from the mental health/ rehabilitation service delivery system? What can be expected from the patients/ clients who are in need of such services? And, what are the expectations (attitudes) of the professionals who work in the service delivery system and interact with the consumers of service? Once we have discussed what might be expected in practice, we will examine the relationship which exists between the practitioner and the individual who is psychiatrically disabled, the various setbacks faced by the rehabilitation practitioner as the goal achievement process is activated and finally how regrouping can occur as a function of the process of care continuity.

A FRAMEWORK FOR THE PRACTITIONER

Expectancies of the System

The literature that does exist in the field seems relatively clear and unequivocal that if rehabilitation efforts are to be successful with the population of persons with psychiatric disabilities, and particularly those with a chronic illness, programs and services within the system must be conceptualized and implemented within the framework of an integrative model. Such a model utilizes multiple resources which have prearranged linkage relationships at the community or inter-agency level as well as at the agency level. In reality however, such inter-agency linkages are more fiction than they are fact. The problem is not a new one, and in fact, proposals to deal with inter-agency cooperative agreements and schema for inter-agency coordination date back into the early 1970's.

One such model (Black, 1976) utilized a decidedly structural approach to the problem. While acknowledging that the areas of life which must be linked in the provision of "support services" for any human being are "housing, socialization, recreation, education, work or other means of economic support, and necessary medical and psychiatric treatment services" (Black, 1976, pp. 37-38), the "linking" function in this model is confined to a discrete entity, a "Day

Center"(p. 36). The Center would have "physical space with minimal staff and volunteer services" and would provide "four essential rehabilitation functions," namely: "1) (t)he availability of treatment continuity; 2) (p)rovision for advice and guidance or an advocacy function; 3) (t)he opportunity for continuity of contact and of observation of ex-patient behavior," and "4) (t)he provision of some direct specialized support services as may be necessary depending upon the actual characteristics of the population to be served" (p.37).

The difficulty with such a structural model is that it posits responsibility for coordination of services on yet another agency in an already existing multiple-resource system. As such it faces two major obstacles to success: (1) credibility in the community of professionals whose expertise, successes and failures are going to be somehow linked by "minimal staff" and volunteers; and (2) the ultimate segregation of a population of persons with psychiatric disabilities who would be inclined to use the facility as a substitute public institution-type day room. Black does acknowledge the difficulty in terms of funding to "get governmental budget interest in a Day Center as a specialized institution" (p.40), but in so doing he obviates the entire concept of an integrated model of service delivery. Instead of integration we have a new agency vying for funding, client, acceptance and its piece of the turf. Finally, as with most well-meaning advocates, who must make a strong case for their own wares in the marketplace, Black relegates issues of housing , education, and employment to positions of lesser prominence within the broad domain of mental health endeavors.

> We should be less concerned that mental health authorities provide decent housing for ex-mental patients, but rather with how the mental health providers keep sufficiently in touch with ex-mental patients to provide them with what they require when they are in need of treatment. It is actually the responsibility of the institutions of society to deal with the living arrangements for these and other destitute or unfortunate human beings who require roofs over their heads and food and clothing (p.38).

Such an approach with its focus on a structure which casually places the responsibility for care support services on "other institutions of society" is out of step with a comprehensive approach to treatment and/or rehabilitation. In the words of Lamb (1981): "Community residential care is one of the most important arenas in today's struggle to create quality programs for the chronically mentally ill" (p.1). The importance of residential rehabilitation services has been recognized by the Department of Public Welfare of the Commonwealth of Pennsylvania. This recognition has lead to the formulation of regulations regarding their operation (8600 Mental Health-Community Residential Rehabilitation Services, Pennsylvania Bulletin, Vol. 12, No.19, Sat., May 8, 1982, pp. 1487-1499).

> Community Residential Rehabilitation Services (CRRS) are specifically designed and operated to assist persons with chronic psychiatric disability

> to live as independently as possible through the provision of training and assistance in the skills of community living and by serving as an integrating focus for the person's rehabilitation. CRRS can exist only in a system of services for their clientele and cannot function without ties to other service providers. Rehabilitation of severely psychiatrically disabled individuals requires many and diverse services. CRRS have an obligation to work cooperatively with other service agencies and with local coordinating and planning groups toward the development and operation of a comprehensive service system which can meet the needs of chronically mentally ill persons in a continuous, timely and coordinated manner (Section 8601.2, p. 1487).

Thus, these regulations, while directed toward the functioning of residential facilities, make it clear that linkages within and between diverse services are essential to the rehabilitation of persons with chronic mental illness and that there is an obligation imposed by law to work cooperatively in the development and operation of a comprehensive service system.

Schumacher (1980) recognizing, at least implicitly the pitfalls created by the kind of model proposed by Black, suggested that the coordination of services at the agency level may be less feasible than the coordination of services at the client level. In so doing Schumacher recommended the assignment of client advocates and follow-along personnel during or at the time of the client's hospitalization who remain with the client throughout long-term adjustment. In his proposal a specific group or consortium of agencies would "develop and implement the "position of mental health advocate who has contact and referral skills" (60). The agency is replaced by a person who will now integrate and coordinate the services needed by individual patients/clients. In addition, Schumacher suggested:

> Overlapping programs should involve the local city-wide or county-wide consortia of agencies that could be directed by a joint team with central administrative responsibilities. This would include the total health care of the chronically mentally ill patient (p. 60).

His suggestion is perhaps as self-defeating as that of Black. Schumacher would have his joint team "direct" the total health care of clients through a central administrative structure. However whether it be a jointly appointed advocate or a joint administrative team, the function and therefore the process is the issue far more so than the mechanism, the agency, the person, the team, the contractual agreement or the regulatory standards. The function or process is that of case management. Often, however, when this function is relegated to a specific agency or individual apart from the existing cadre of services, it becomes even less the concern of the multiple professional rehabilitation providers than it already is [illegible]me cases.

One model adopted by a large Canadian psychiatric hospital (Waylenski, Plummer & Littman, 1981), while directing its efforts to the aftercare of specific problem patients, is demonstrative of a process, functional approach without specific superimposed structural (facility, staff administration) components. Staff commitment to community placement as well as an understanding, both affectively and cognitively, of the crisis of discharge for many patients were seen as essential attitudinal components. In addition, five features of the program were seen to have contributed to its effectiveness: 1) an aftercare assessment which others have conceptualized as a service plan; 2) community-institutional team planning meetings, weekly and monthly with varying levels of staff and community participation; 3) a transitional staff member who would be available to patients as a constant, benign and enabling body to move throughout the institution and community, including home visits; 4) an approach to patient care which is immediate and frequent particularly in the immediate period following discharge; and, 5) the establishment of personal relationships with the staff of as many community-based aftercare services as possible. "We have developed a small but highly effective transitional program to facilitate aftercare for such patients and a minimum of formal procedures and without additional personnel. Moreover, the program has shown very low re-admission rates" (p. 496).

Among the summary of recommendations by the Switzer Fellows on the topic of Schumacher's paper (Switzer Fellows, 1980), the following quotation highlights the issue of an integrated model of service delivery from the perspective of case management.

> There needs to be greater emphasis on the role of case-management, including advocacy, to facilitate client access to services. This should begin during or at the time of a client's hospitalization or entry into the system, and remain with the client throughout an essentially open-ended rehabilitation process. Case-management is viewed here as an important and necessary function which can best be provided by professionals of varying disciplines. It may best be provided by the individual with the strongest relationship with the client. Case-management is a process of 'tracking people' and not paper!(p. 67)

Expectancies that Relate to the Patient Population

Krauss and Slavinsky (1982), in a very cogent fashion, present a rationale for viewing chronic illness, much like our system of care and rehabilitation, from an integrated approach. Specifically, it is postulated that no one current theoretical perspective on chronic psychiatric illness whether it be medical-technical, epidemiological, sociological, intrapsychic or the mental illness myth model can account for the phenomenon of chronic mental illness or psychiatric disability. They point out that chronic psychiatric illness is not a diagnosis or a specific diagnostic category, it is not unique to a particular age group and it is not a social class related phenomenon. Rather, Krauss and Slavinsky (1982) characterize a chronic disorder as differentiated from an acute or transient situational disorder, as: "severe, permanent, stigmatized and contagious" (p.20).

The severity of a chronic illness is often difficult for the practitioner to comprehend much less mitigate. Recognition of the "enormity of the burden of the illness to patient and others is a prominent feature of chronic illness" (Krauss & Slavinsky, p. 20). The practitioner gets merely a glimpse of the degree of impairment during a therapeutic session, for example, when the patient moves in and out of the real world and constantly seeks reassurances in relation to past events, fears or delusional material.

One such individual, while discussing experiences in a partial hospitalization discussion group which focused on the patients' perceptions of themselves and their concerns about the perceptions of others, abruptly asked her therapist if she would ever have a baby. She then began a dialogue with herself on whether ex-prisoners were worse than ex-mental hospital patients, finally concluding that Patty Hearst surely had friends and someone had married her. During one particularly stressful period during which her medication dosage appeared to be exacerbating her painful symptomatology, the patient desperately fearing reinstitutionalization took to bed rest. A caring family then served as "in-home" hospitalization. Mother acted as competently as any skilled nurse until the acute exacerbation subsided. In this particular case, because of the family's long-term commitment to the care of this young woman, rehospitalization did not occur, medication was readjusted based on years of experience in observing and monitoring their daughter's behavior, and the patient who had recently been terminated from a work adjustment program because of absenteeism, was able to reenter a partial hospitalization day program.

Throughout the experience family and patient sought reassurances from the therapist that the painful, anxiety-ridden, panic-like state would subside and the patient would be able to continue with her rehabilitation process. Instead of regarding the acute episode as a failure of treatment, the therapist reinforced the strength and motivation of the patient to regain her hold on reality and return from her delusion-ridden preoccupations and hallucinatory thought processes. Her pain was real and her impairment severe to the degree that engagement in social relationships or work experiences was impossible. Flexibility in a service delivery system which would facilitate the patient's re-entry into a less stressful day program was of paramount importance. Without an appreciation of the severity of chronic psychiatric disorders such use of the system would not have occurred.

Permanence of psychiatric disability is a factor which must be faced by the rehabilitation practitioner in much the same manner that a chronic physical disability is accepted. And yet, while a sense of hopelessness often pervades the rehabilitation process with persons who have severe psychiatric disabilities, this is not the case when an individual patient or client has a diagnosis of diabetes or blindness. If rehabilitation is to be successful in the case of the chronic physical illness, acceptance of its permanence is seen as a positive step in the life adjustment process in spite of periods of exacerbation, medication adjustment or other complicating medical factors or sequelae. In writing about the chronically mentally ill Krauss and Slavinsky (1982) point out that the illness may be episodic, "marked by periods of remission and exacerbation" (p.22) They continue:

> This episodic phenomenon, with its waxing and waning of symptoms, has become more serious and noticeable in the wake of deinstitutionalization.These episodes were simply less noticeable and less important in total care institutions where the vast majority of the chronically ill previously spent their lives (p. 22).

The stigma of psychiatric illness has been well documented in the past and continues to exist. According to Goffman (1963) the term stigma refers to an attribute of a person that is deeply discrediting, and by definition the person with a stigma is perceived as not quite human. "On this assumption we exercise varieties of discrimination...we construct a stigma-theory, and ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences..."(Goffman, p. 5).

In a study by Wicas and Carbuccio (1971), counselor attitudes toward the culturally deprived black, the ex-mental patient, and the ex-convict were examined. A total of 112 rehabilitation counselors and school counselors were asked to respond to a forced choice questionnaire regarding their client preferences in various situations. The culturally deprived black was most accepted by the counselor and by society, as the counselor perceived it. The ex-mental patient was seen as "least acceptable for positions dealing with trust and responsibility, least in control of his fate, and least able to be helped by community programs (Schumacher, 1980, p. 51).

In another study, Hartlage and Roland (1970) investigated employer attitudes toward the former mental patient, the persons with mental retardation, and those individuals with major amputations with respect to work-related behaviors. While those with amputations were considered average or better than average employment risks, the former mental patient and the person with mental retardation were regarded as below average and poor employment risks. There was, moreover, the greatest concern expressed among the employers for persons with psychiatric disabilities and their tolerance for work pressure.

The rehabilitation practitioner, then, cannot be overly condemning of the employer or society-at-large in their response to persons with mental disabilities and the negative attribution process which follows. The counselor must come to grips with his own prejudice and fears, whether real or imagined, if he/she is to effectively deal with the stigmatized patient. In the case of the patient discussed previously, a former therapist had told the patient that she should never have

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children and to put that idea out of her mind. For the patient, that directive became a preoccupation as she attempted to deal with her sense of self-worth. Were ex-mental hospital patient's "better" than ex-prisoners? Were mentally ill people as bad as mentally retarded persons? Would any man ever want to marry her knowing of her psychiatric history? Could the people she encountered on the bus tell that she had been in a state hospital? The family also struggled with her stigma as they contemplated moving to another state so that she "might have a fresh start."

The stigma attached to the psychiatric disorder then leads to a sense that the illness is contagious. It may be "detrimental to others" or "put others at risk" (Krauss and Slavinsky, 1982, p. 28). Inheritability and predisposition for particular psychiatric disorders are real issues. The vulnerability of children to a parent's episodic illness, the stress on other family members particularly if financial resources are limited, and the daily strains of coping with bizarre or inappropriate behaviors, periodic deterioration of living skills, neighbors and relatives' questions etc., cannot be overlooked.

In summary, the characteristics of a chronic psychiatric illness, severity, permanence, stigmatization and contagion are what the rehabilitation professional can expect to encounter in working with this population. They must be dealt with in a realistic manner. Otherwise, the practitioner can be overwhelmed by his or her reactions to this group of individuals. Olshansky (1980) in writing about persons with chronic schizophrenia points out that many are not likeable, they are "unkempt, uncooperative and unpredictable" (p.127). They are perceived of as educational and vocational failures, chronic losers and at times frightening. There is at times a tendency to not forgive them their misfortunes and to resent their dependency. How far can the practitioner stretch the theoretical concepts of empathy, unconditional regard, positiveness and genuineness?

Test and Stein (1975) point out that while their treatment emphasis is on ways to increase appropriate, adaptive behaviors in a patient's repertoire, there are times when a more direct way of dealing with inappropriate and antisocial behavior is necessary in order to attain treatment goals. "Social learning theory is abundant with examples of the fact that behavior is responsive to its consequences. Toward these ends we have found that holding patients responsible for their behavior is an effective means of minimizing inappropriate and antisocial behavior" (p. 78).

> We adamantly disagree with the argument that direct feedback will be untherapeutic because it will cause a patient to 'fall apart'. Our experience indicates that although it certainly may be stressful, one of the key ways any individual learns to behave appropriately is by being given accurate information about the effects of his behavior. Murphy et al. (1972) made this point well by stating, 'It is unclear to me how a patient will ever relearn to please others and obtain pleasure in return if...disapproval is always co[illegible]d' (pp. 14,79).

Finally, as we conclude this section on expectancies, it is important to recognize that as research continues in the area of the severe psychiatric disabilities, some investigators and practitioners are becoming increasingly convinced that the population is not a homogeneous one in terms of expectation levels. Hogarty (1971) writes of low tolerance for stress and high tolerance for stress subgroups. Others (Easton, 1974; Lamb and Goertzel, 1972; Wilder, Kessler, and Caulfield 1968; and Richmond, 1969-70) have looked at high and low expectation halfway houses, while still others have investigated high and low expectation vocational programs (Koltuv and Neff, 1968; Loeb & Scholes, 1966; Bond & Dincin, 1986).

In the Lamb and Goertzel (1972) study, long-term mental patients were randomly assigned to one of two community settings. In the high expectation settings which included a halfway house, a day care center and a vocational workshop, the patients' level of vocational and social functioning were found to increase, with the high expectation group less likely to be labeled as deviate, less often stigmatized, and less segregated. However, there were a group of patients for whom high expectation settings were not appropriate, but who were able to continue to function in low expectation environments.

INTEGRATING A KNOWLEDGE BASE INTO PRACTICE

The Relationship Between the Practitioner and the Client

While current treatment practices with individuals who have chronic psychiatric disabilities have focused on medication and a variety of social support and group experiences, there is reason to believe that a need exists for a supportive psychotherapeutic counseling relationship as well. Just as the patient with a chronic mental illness moves at times episodically into the acute phase of his/her illness, this same movement occurs in and out of established programs and group settings. Without a supportive and ongoing one-on-one relationship, the patients' attempts at rehabilitation become fragmented, disconnected and highly stressful at each point when program and service options need to be renegotiated. This supportive other can be a mental health clinician, a rehabilitation counselor, an activities or expressive arts therapist, or a residential advisor. But in any case, that practitioner must be properly prepared to deal with the uneven course of the rehabilitation process where the individual with a chronic psychiatric illness is concerned. The practitioner must provide the experience for a trusting relationship, a means to understand the stressors which precipitate problems, an ongoing listener for expressed feelings and concerns whether pathological or healthy, an energizer for corrective actions and alternative behavioral strategies, and an accepting, caring respondent when things go wrong. "The patient-therapist relationship...transcends professional discipline and theoretical bias. The very act of investing energy in the establishment and maintenance of an individual relationship with someone who has a chronic psychiatric illness lends a kind of validation to (the) person and their life's experience" (Krauss & Slavinsky, p. 203). For an excellent discussion of the supportive therapies and their practice the reader is referred to Krauss and Slavinsky's (1982) **The Chronically Ill Psychiatric Patient and the Community**, Chapter Seven, The Supportive Therapies. A recent investigation, which will now be discussed in some detail, highlights for us the importance of the therapeutic relationship to the rehabilitation of the severely psychiatrically disabled.

In an effort to evaluate the effectiveness of strategies to return persons with chronic mental illness to the work force, a pilot project was implemented and tested by Ciardiello (1981). Program effectiveness was evaluated in terms of vocational rehabilitation outcome/employment status, clinical outcome, career maturity outcome, program participation and implications for work. Thirty-two continuing care clients from the Community Mental Health Center of Rutgers Medical School were selected for the study on the basis of meeting specific criteria which defined chronic mental illness. The pilot program provided services to each patient on a full-time, daily basis for a period of seven months. Following a battery of pretests, 16 subjects were randomly assigned to a control group which received existing rehabilitation services only. Sixteen were also assigned to the experimental group which received the pilot vocational rehabilitation program in addition to existing services.

Results of this study, while necessitating somewhat cautious interpretation because of certain methodological shortcomings including the absence of blind raters, nonetheless merit review in light of the preceding discussion on the relationship between the client with a chronic psychiatric disability and his or her therapist or counselor. Ciardiello (1981) reported a significant correlation between the number of individual counseling sessions attended by program participants and employment status which was defined as paid employment. The more individual counseling sessions attended, the more likely was the program participant to be employed. In addition, the amount of time spent on individual counseling was highly correlated with the amount of time participants spent in group counseling sessions. Ciardiello concluded; "The results discussed above suggest that the individualized attention characteristic of the client-counselor relationship was an effective component of this pilot program and a key variable in the vocational success of the chronically mentally ill" (p. 33). And although not statistically significant, the total amount of time worked by the experimental group exceeded that for the control group.

In terms of results reported on the various rating scales employed, the experimental group subjects were rated significantly higher than the control group on five of twelve ego functions including reality testing, judgment, regulation and control of drives, thought processes, and adaptive regression in the service of the ego. Results from the SCL-90, a measure of psychiatric symptom level, found the experimental group reporting fewer psychiatric symptoms than those individuals in the control group. The hypothesis that the stress associated with working and/or involvement in a work program increases psychiatric symptomatology was not found to be the case" (p.38).

Overall, results of the study suggested that: 1) The more times clients had spent working prior to becoming or involved in the study, the less likely they were to become involved in counseling; however, the amount of time they spent in counseling was positively related to the amount of time they worked during the program. 2) There was an association between levels of career maturity and the clients' willingness to attend counseling sessions, both group and individual. 3) Counseling appeared to increase the participants' motivation to work. And finally, 4) Certain aspects of ego-functioning were affected by counseling while others were not. Ciaridiello concluded:

> Given the short duration of the program and the bleak, general employment picture which existed at the time of the study, the results....suggest that there are useful techniques available to assist psychiatrically disabled clients to enter the workforce. The results of this study suggest that counseling is a crucial element in such an effort....(p.42).

The relationship between the practitioner and the client with a psychiatric disability is, then, the glue, so to speak, which enables the rehabilitation process to stick together or in its absence, become unglued. Krauss and Slavinsky (1982) have suggested certain necessary ingredients in the therapeutic relationship with this population which deviate from the approach of more traditional psychotherapy relationships. "Expressions of opinions, genuine agreement or disagreement with the patient, and well-chosen acts of self-disclosure will all help to make the person of the therapist a viable part of therapy" (p. 203). Appropriate expression of emotion on the part of the therapist to the events and issues which comprise the therapeutic dialogue is seen as a mechanism whereby the individual patient or client can learn about the reciprocity of relationships. They conclude:

> There is a particular bittersweet quality to developing a psychotherapy relationship with someone who has a chronic psychiatric illness. One can neither ignore the real deficits caused by the illness nor fail to be attracted by the tenacity, and perhaps, the vulnerability of the person who is afflicted. There is much that is unattractive about a chronic psychiatric illness, but the establishment of an individual relationship moves beyond the illness to the person and is often the medium for new-found hope on the part of the therapist and the patient (p. 204)

THE NECESSITY FOR GOALS

The Goal Setting Process

Psychiatric rehabilitation by its very nature is a goal directed process and as such implies a change in the individual client/patient's current level of functioning which is somehow negatively perceived or experienced. Whether that goal be symptom reduction, alleviation of stress, an increase in socially appropriate behaviors, maximization of independent living skills, or vocational competence, all goals are contingent upon the validity of the assessment of the particular individual's strengths, deficits, psychopathological symptoms, support systems, natural environment, motivation and ability to change. Goal attainment is ultimately connected with an understanding of the individual with a psychiatric disability regardless of the setting in which the rehabilitation process occurs. As mentioned previously, high and low expectation studies conducted with ex-mental hospital patients, who have subsequently been moved into a variety of residential treatment and vocational programs, have given us some insights about the appropriateness of goals and the congruity of these goals between the individual patient/client and the rehabilitation practitioner (Easton, 1974: Lamb & Goertzel 1972; Loeb, Kaufman, Silk-Gibran, & Gioe, 1974; Menapace, 1977; Richmond, 1969-70; Wilder, Kessel, & Caulfield, 1968).

In reviewing the literature on halfway houses for psychiatric patients in the community Wilder, Kessel and Caulfield (1968) identified two contrasting rehabilitation approaches to transitional residences. One they labeled "nurturing," which emphasized the "illness" aspects of the residents and the other the "high -expectations" approach, which appeared to be directed at the "health" of the individual (p. 103). Their retrospective study of 42 residents of a high-expectation halfway house in New York revealed that older, better motivated more employable residents, who generally had neither severe adjustment problems with their families nor severe clinical symptomatology, did best in the high-expectation setting. Younger patients, on the other hand, closer to the adolescent onset of their illness, required a separate more structured nurturing environment. In addition, there were those individuals who, having benefited from the residential program, were to successfully return to their families as opposed to living independently. In differentiating the success from the failure group in this study, the authors found the failure group (rehospitalized suicides, inappropriate use of the residence as a manipulative device with significant others) to be younger, with more severe symptomatology, poorer family adjustment, and less motivation to enter the residential program in the first place The most striking difference between the two groups was in their ability to gain rapid employment (within one month of residence).

The authors cautioned, however, that the use of vocational status as both a predictive variable, the ability to gain rapid employment, and as a criterion for defining success, the ability to gain and maintain employment, is objectionable. Rapid employment can be easily manipulated by a facility that merely requires its potential residents to have been gainfully employed for several weeks while on hospital passes. Forty percent of the residents were rehospitalized within a year after entering the residence. This outcome seemed to have been influenced by the young age, single status, and inability of the group to live either with their family or to make it on their own and made "our sample more vulnerable to rehospitalization than the general population of discharged psychiatric patients" (p. 107). Finally, the study's investigators concluded that the pre-established time limited goal of six months of transitional residence was not appropriate for this population. This finding resulted in the introduction of a nine-month time limit residential goal: "three months to get settled, three months to enjoy it, and three months to prepare for leaving--a true rebirth" (p. 108).

In the Lamb and Goertzel study (1972) which utilized a random assignment of ex-state hospital patients to high or low expectation programs in the community, patients who were assigned to the high-expectation setting were not less likely to be rehospitalized than those in the traditional low-pressure setting. However, the contribution of the high-expectation setting was that of increasing the patient's level of vocational and social functioning. Two years after referral, "one half of the patients in the demonstration group were involved in structured activities more than 90% of the time, either in a vocational capacity or in fulfilling the role of a housewife, while only one in five in the comparison group were so occupied" (p.134). Those in the demonstration group were also significantly more involved with other people. In terms of long-term and short-term goals progression from a facility where social skills were learned prior to engagement in a vocational program was not particularly effective for many of the long-term patients. In discussing this issue, Lamb and Goertzel reported that many of the residents experienced difficulty in the day treatment center where social and verbal skills were emphasized and appeared to have greater success if they went directly to a structured vocational program where social skills were learned in the vocational setting in the halfway house. "In some cases the expected improvement in social skills did not occur but the client derived great satisfaction from his vocational progress. Most of his gratification in the community and heightened self-esteem may stem from the world of work" (p. 134.).

The authors concluded their discussion of the efficacy of such high-expectation programs for persons with chronic psychiatric disabilities with the observation that as "mental heath professionals are unable to predict with any degree of consistency which long-term patients will, in fact, benefit from exposure to a high-expectation program.....we feel this kind of program should be offered to all long-term patients entering the community" (p. 135).

A follow-up study was conducted on two groups of clients who had completed a rehabilitation program at Horizon House in Philadelphia, Pennsylvania, those who had retained employment and those who had lost their jobs (Loeb, Kaufman, Silk-Gilbran & Gioe, 1974). The groups did not differ in demographic characteristics: 1) length of last employment; 2) estimated total lifetime employment; 3) length of number of previous psychiatric hospitalizations; 4) duration of program involvement, or type of employment. However, the job retention group differed significantly from the unemployed group in that: 1) more of them had learned of jobs on their own; 2) their perceptions of job duty or expectations were consistent with employment realities; 3) their satisfaction with their work was greater; and 4) their willingness to inform supervisors and peers of their psychiatric histories was more prevalent.

The results of this study suggest rehabilitation goals which: 1) address the encouragement of more independent job-getting and/or the interpretation of already assured jobs as "still dependent upon the client's initial interview with the 'potential' employer" (p. 170); 2) a rethinking of and more realistic approach towards counseling clients with regard to the sharing of information about their psychiatric involvement; and, finally 3) the need for additional counseling services following program completion to "provide continued support and to assist in the identification and remediation of job-related problems" (p.171). This last recommendation was predicated on the fact that most of those individuals in the study who left their jobs were "unhappy for a long period before doing so and then typically left with little or no notice" (p. 171). Such results add to our understanding of the goal planning process which must constantly take into account an ongoing process of assessment of current functioning, goal reformulation, and client participation in the goal setting process.

The Nature of Goals

The goal-oriented rehabilitation process with the client who is psychiatrically disabled is not one smooth, consistent or even progression. Thus, the concept of long-term goals takes an added dimension with this population, which then colors the desired end or outcome. That dimension is time itself. Specifically, the practitioner must take into account not only the "timing" of the steps in the rehabilitation and/or treatment planning process, but also the time required to achieve mutuality of goal acceptance, the time taken up by set-backs in the client's goal attainment, and the time needed for continued, supportive follow-up and follow-along. The dimension of time has a topographical character, with its high points (achievements), plateaus (stabilization and maintenance periods) and low points (regressions, crises, unforeseen complications). Realistic goal planning must of necessity deal with shorter terms, discrete, tangible time-segmented objectives. Otherwise, long-term goals will for all time appear unattainable by both the practitioner and the patient/client.

Having addressed the temporal aspects of the goal-oriented rehabilitation process, it is important to point out, or in some cases reiterate what the reader may have already gleaned from the discussion, certain issues which affect or influence the quality and substance of the goals themselves. Intermittent hospitalization and the need for brief and/or longer-term treatment of the symptomatic characteristics of the illness are realities in the long-term adjustment period of the individual. There are those individuals for whom the attainment of independent living or semi-independent living with the opportunity for a pre-arranged and structured social support system is an appropriate rehabilitation goal. On the other hand, social skill acquisition, in and of itself, may never be attainable. There may be those individuals who would seem to fair better in protected work-oriented settings where the goal of rehabilitation is the maintenance of their work skills and productivity, which perhaps in a singular fashion would reinforce the individual's self-worth and sense of personal identity. When work is the goal and it is quite obviously not a rehabilitation absolute, preparation for work should be graded and job placement accomplished with the expectation of interruptions and breaks in the employment process. Moreover, "overly vigorous rehabilitation efforts can have negative results with clients who may need 'low-expectation' settings" (Schumacher, 1980, p. 58).

Finally, while what we have said thus far about goals implies a concept of reasonableness or rationality and collaboration in the goal formulation process, goals must also possess a quality of measurability. Goals, in and of themselves, while exceedingly high-sounding, significant and worthy of achievement, tell us nothing about how they are to be attained or as Roger Mager (1972) so aptly remarked "how we will know one when we see one" (p. 11). The patient/client and the practitioner need to have identified patient performances which when summed up result in mutual agreement on goal attainment. Goals, then, which are based on thoroughly assessed problem areas, are contingent upon patient-specific performance measures and practitioner-specific or agency-specific operating procedures or methods. Lastly, they are conceptualized and implemented within a specified time frame, the complexities of which we have previously discussed.

The establishment of goals is at the very essence of the practice of psychiatric rehabilitation. Their implementation and attainment is a vital function for anyone in the role of a rehabilitation practitioner. Goals for living are inherent in the human condition and as such are essential to the quality of life of persons with psychiatric disabilities.

SETBACKS IN THE REHABILITATION PROCESS

Managing Episodic Illness: Crisis Intervention

"Clinical experience has shown us that most long-term psychiatric illnesses, when viewed in their totality, are episodic in nature. This happens even with continued treatment and compliance with treatment regimes" (Krauss & Slavinsky, 1982, p. 101). These authors adeptly describe the predicament which then faces the rehabilitation practitioner who "must learn to live with uncertainty" (p. 102).

> What is meant by uncertainty in this context? Very simply, it means tolerating a lack of understanding about the etiology of chronic illness, about the long-term course of treated chronic illness, about ultimate prognosis, or even about the mechanisms of action of most treatment

> techniques. It means...to try something new...creating something new...to assess the effectiveness of a treatment plan, to admit that it is a failure, to reassess, and then start all over again.. to admit to oneself that there is a great deal that one does not yet know...admitting to the patient that one doesn't know everything...dismissing the thought of transferring the untractable patient as one's immediate reaction to getting nowhere...It means working very, very hard (pp. 102-130).

With the chronically psychiatrically disabled the intermittent nature of their illness may be viewed in terms of crisis theory. Krauss and Slavinsky (1982) postulate that any change in the life situation of these individuals, whether it involves symptom exacerbation, changes in roles, treatment personnel or issues or environmental fluctuation, etc., which requires additional coping or readjustment on the part of the patient may be considered a crisis. Relief for the immediate stress or and prevention of further deterioration are of paramount concern. And, as we have pointed out at an earlier time, the intermittent, episodic nature of a permanent and severe psychiatric disability is not diagnosis specific. That is, it is not only in the case of chronic schizophrenia that the illness is marked by episodes of crises and resultant regression. Several cases will now be discussed which illustrate this point.

One case involved a 20-year-old female with a diagnosis of anorexia and bulimia. This young woman spent the greater part of her childhood in a residential rehabilitation program because of a learning disability and severe acting out behavior which manifested itself in tantrums and physical attacks on other family members, particularly her mother. At the time of her referral to the psychiatric rehabiliation service, she was hospitalized on account of her anorexic condition. Rehabilitation efforts over a two-year period following this hospitalization were directed at vocational planning and family therapy. Over that period of time she was rehospitalized once for acute symptom relief (significant weight loss) and unsuccessfully attempted three separate vocational programs.

Prior to the patient's most recent crisis, this young woman's counselor had shifted focus from vocational planning to more psychotherapeutic issues, involving her emancipation from the role of child and her need to assume a measure of responsibility for her personal behavior. During this time the patient began to disclose previously secreted information regarding her continued physical aggression towards mother and her sexual promiscuity, which had been employed in an effort to establish some sense of self-worth by the patient. Within a period of six-weeks following her last hospitalization she had gained 35 pounds and while still binge-eating she was no longer bulimic. The patient blamed mother for the weight gain, and while both her counselor and family therapist were away for a week's period, tried to have herself again admitted to the hospital. Admission was denied and subsequently the patient cut her wrists, just enough to get herself admitted to a local community hospital. Once there she requested a transfer so that she could again be placed on a diet in the specific treatment unit she had previously been a part of and where she could be with her friends. In consultation with the counselor, the local hospital agreed not to transfer the patient to her former setting.

Another case involved a 47-year -old married male with a history of alcohol abuse, depression, a seizure disorder secondary to childhood measles and encephalitis and a progressively deteriorating organic brain disease. This individual had been known to the mental health and vocational rehabilitation system over a number of years and had previously been trained as an orderly. He was followed on a regular basis by a psychiatrist for both his medication needs and supportive therapy and was referred several times over a five-year-period for vocationally oriented rehabilitation services. He had been previously arrested for attempted manslaughter and was known to brag about his physical strength ("my hands are lethal weapons") in order to intimidate others whenever he was placed in a new situation that was anxiety producing. In addition, he had problems with excessive profanity in his verbal language, which while partially organically based, would deteriorate further when increased anxiety further limited his voluntary efforts at control.

At the time of his most recent referral to the psychiatric rehabilitation service, the patient had expressed an interest in performing some meaningful activity even if he could no longer return to work. Over the period of three months, the counselor worked out a voluntary position at a local vocational workshop which was of particular interest to the patient and began to prepare him for his initial interview there, with special emphasis on appropriate personal disclosures and statements of bravado. In the meantime, his wife was also seen to help develop job seeking skills, as the patient's disability income was no longer adequate to support the family and his eventual employment became less and less likely.

One week following a very successful "practice" session with his therapist, the patient arrived at his interview for the volunteer position and began by immediately telling the interviewer how he had held a knife to his brother's head when they were children and of the many times he nearly bludgeoned people to death during a fight. Needless to say, the interviewer became terrified and terminated the process. The patient had then regressed under the stress of a new condition to previous maladaptive behaviors and was not able to carry through the successful practice session in the counselor's office to the new setting.

The final case which we will discuss is illustrative of another existential dynamic in the life of a former patient, namely the flight into health. A 40-year-old divorced, Russian-Jewish immigrant with a previously diagnosed schizoaffective disorder was seen by a counselor in the psychiatric rehabilitation program for a period of one year. She entered vocational counseling with aspirations to become a computer programmer. She had been a drafting instructor in the Soviet Union previously and had on her own, after relocating to this country, completed a computer training program. While she did poorly in the training program, she continued to seclude herself in her room to study computer manuals and proceeded to lose a series of three different jobs as a computer technician in a matter of weeks. Being a proud woman, in addition to secluding herself in her room to study, she also avoided leaving the house or interacting with anyone on a social basis because of her embarrassment at being on welfare.

As counseling continued, however, the patient reformulated her vocational goals and made a decision to enter the barbering profession, having found a mentor who was willing to employ her once she completed barber's school. Arrangements were then made with the local Office of Vocational Rehabilitation to fund her course of study. Over the next several months the patient began to improve her appearance, she no longer hid in her house, and found a part-time job as a manicurist. Feeling much more at ease, self-assured and less depressed, she took herself off of medication to which her primary clinician, unbeknownst to the counselor, acquiesced. Within a few weeks the patient became overtly psychotic, was rehospitalized, and while on the inpatient unit tried to strangle herself.

In all three cases, the rehabilitation counselor would begin again to help restabilize the client, reestablish mutually agreed upon goals, and continue to work with the patient once the crisis state had come under control. At no time did the counselor abandon the patient and in two of the cases reestablished the working relationship during the inpatient stay.

Krauss and Slavinsky (1982) summarize the goals of crisis intervention with the patient with chronic mental illness as follows: 1) symptomatic relief; 2) hope; 3) maintenance in the least restrictive settings; 4) support for family and significant others; 5) stabilizing the course of the illness; 6) growth; and, 7) preventative education. These three cases serve to illustrate the operationalization of these goals. Helping a patient to live with uncertainty while simultaneously helping him/her to gain maximum control over his/her life and illness is one of the most important aspects of the role of the rehabilitation practitioner. "If it is difficult to be the clinician involved in the management of an episodic illness, the difficulty nowhere approaches that of being the individual who must experience such an illness" (Krauss and Slavinsky, 1982, p. 130). These authors conclude:

> Although there may be continued problems and discomfort, it is not the end of the world. Learning to swing with change is a a large part of being an adult in our world...Not all anxiety, sadness, or negative feelings are'bad' for a person. Everyone experiences them. It is always possible to grow...(p. 131).

Secondary Gains and Psychiatric Illness

In addition to the complexities of working with individuals who have a chronic, episodic illness, two other issues emerge in the process of psychiatric rehabilitation which influence the role of the rehabilitation practitioner, and which can be viewed as setbacks. The issue of disability income maintenance and the secondary gains to be derived from clinging to the role of a sick person have been addressed by Lamb and Rogawski (1978). The second issue, staff burn-out, has also been discussed by Lamb (1979)

While beneficial consequences for persons with psychiatric disabilities may be derived from a source of income when they are unable to work or support themselves by other means, in some instances the availability of Supplemental Security Income grants have had negative effects in the maximization of the individuals' potential for meaningful and /or productive activity. On the one hand, as Lamb and Rogawski (1978) point out, the change in the name of the funding mechanism from Aid to the Disabled to Social Security Income has had an important effect on delabeling and destigmatizing the funding in the eyes of persons with psychiatric disabilities. In addition, medicaid and food stamps which have been added to the basic federal grant are exempt from taxation. When these benefits are pooled with the resources of another recipient, the standard of living achieved may be greater than the individual could obtain from certain low-paying sheltered employment situations or low-level competitive jobs.

With a move in the recent past by certain states to tighten up grant allocations, numerous psychiatrically disabled clients were among the "able-bodied poor" who would only be eligible for a three-month period of funding within any calendar year. Having received notices of their grant terminations, many patients appeared at psychiatric rehabilitation services requesting vocational evaluations, training and/or job placement. Within a matter of several weeks to a month, advocates for the disabled had either stopped the process of eligibility determination in some cases or had succeeded in exempting certain disabilities from the review process. The same fear which had motivated these patients to seek vocational services now served to return them to their previous levels of apathy and self-styled security from the pressures of daily existence. Since the current status of the law still contains disincentives for recipients to secure employment, as significant earned income is deducted from their grant, it is up to the rehabilitation practitioner to insure that comprehensive services are available to these clients and that their progress or lack thereof be monitored. It is the recommendation of Lamb and Rogawski that:

> If clients react adversely, manifest a recrudescence of symptoms, or seem refractory to active help, the professional should at any time in the process be able to reset their goals and accept the clients' limitations and possibly their need for a passive dependent lifestyle that will make minimal demands on them. With this perspective, professionals will leave the door open to treatment and rehabilitation opportunities in the future. In the meantime, they will offer the patient those services that he can or will accept, including the option to call at times of crisis or great stress (p. 1223).

Staff Burnout

Wilder and Plutchik (1981) have identified seven key symptoms of staff burnout in the human service field from which they have proceeded to set up a model for burnout prevention based on a needs assessment, a stressors assessment, and a coping assessment strategy. These key symptoms are: 1) decreased job satisfaction, manifested by decreased ideation and enthusiasm and disillusionment; 2) increased negative attitudes, hardening and avoidance in relationships with patients; 3) staff/co-worker relationships characterized by increased irritability; 4) increased discontent and decreased identification with the organization; 5) increased irritability with family members; 6) increased personal maladaptive functioning, including increased negative self-concepts, exhaustion, apathy, denial, hyermania, physical symptoms, drinking, etc.; and finally 7) a decreased standard of job performance, both qualitatively and quantitatively resulting in a feeling of being trapped or a desire to leave the work setting.

While staff burnout may occur in any work setting, the mental health/rehabilitation world of work is particularly vulnerable to this process. And although the patient population varies from setting to setting and no one population group has a corner on the market, those who work with patients with long term and severe mental illness appear to be particularly susceptible to this existential phenomenon. Lamb (1979) has postulated that as the rehabilitation field has become increasingly committed to serving this population, an influx of inexperienced staff with enthusiasm and good intentions have entered the service delivery system who are unprepared to deal with these new consumers of service, and who in a "year or two...lose their enthusiasm...no longer like their contact with long-term patients,...get bored, frustrated, and resentful"....and "worst of all, become ineffective" (p. 396). For Lamb, the major reason for such burnouts has been the failure of mental health/rehabilitation professionals to recognize that the population of the psychiatrically disabled is not a homogeneous one. These patients differ greatly in their motivation and ability to cope with stress, the types of stress and pressures to which they can respond effectively, and the overall life adjustment they can make with respect to vocational rehabilitation goals or primarily those of a psychosocial nature.

Certain concepts about the practice of psychiatric rehabilitation must, therefore, be understood and addressed if the process of staff burnout is to be prevented or at the very least ameliorated. First, "(M)ental health professionals must accept the slow pace at which most long-term patients progress" (Lamb, 1979, p. 396). Patients/clients will "fail" and they will drop out, some for periods of time and others permanently. But this situation is not so different from the reality of life for all individuals whether they be psychiatrically disabled or not. Perfectio[illegible] as simplistic as it may sound, is not a requirement for human existen[illegible]r has its unattainable nature ever deterred, in any permanent sense, the purposeful goal-directed behavior of the human species. Those of us in the field of psychiatric rehabilitation need always to temper our idealism with a certain amount of pragmatic realism which does not in any way serve to make us negativistic or fatalistic, neither for ourselves or for the individuals we serve.

Secondly, as Lamb (1979) reminds us, while the theory of normalization is a value for modern day practitioner, for many persons it will only be realized in a limited way.

> Some long-term patients may need to live in a sheltered environment that is by its very nature segregated. They may be able to participate only in community activities that are low-key and geared to them and their fellow patients. Their manner and appearance, even with optimal doses of psychoactive drugs and optimal amounts of psychosocial treatment, may set them apart (p. 397).

Such an understanding, however, does not give the practitioner license to collude with the patient in disregarding his ego strengths or to cease in the practitioners' efforts to detect such strengths and the "hidden motivation for growth that often manifests itself in distorted or indirect ways" (Lamb, p. 397). There is an obligation rather to establish realistic expectations of the patient/client and to derive job satisfaction at times from "simply improving the quality of a patient's life rather than increasing his level of functioning": (Lamb, p. 397). At the risk of offending the high minded reader, a homely analogy has more than once come to the mind of this author. Not all of the summer garden's flowers bloom at the same precise moment; it is the unfolding over time that is most rewarding to the tender and to the observer. And, more often than not, the last rose of the season is the most exquisite single blossom unless prematurely smitten by the chill of winter. While our patients are many times difficult to perceive as beautiful and worthy creations of nature, neither are we the practitioners and professionals in the field so totally disposed.

Thus comes our final comment,which has also been eloquently addressed by Lamb (1979). Those who work in the field of psychiatric rehabilitation "must also become aware of their own motivations for working in the helping professions" (Lamb, p. 397).

> To what extent do I get vicarious gratification from my patients' accomplishments or acting out? How much does my sense of being productive depend upon my bringing about significant change in my patients? To what extent am I in this field to get help for myself and to resolve my own problems? How much do I need to have contact with verbal, attractive patients and to be admired and loved by them? (Lamb, p. 397)

Lamb concludes: "A clear awareness of our own motivation and needs can be a crucial factor in preventing later disillusionment or burnout..." ([illegible]98).

REGROUPING: THE NECESSITY FOR CARE CONTINUITY

When in the course of the process of psychiatric rehabilitation the practitioner and the client must "begin again" to reestablish goals after a crisis, symptom exacerbation or other major setback, the backbone upon which the success of the regrouping process will be built is the concept of care continuity. Bachrach (1981) has delineated a set of seven dimensions which she sees as necessary to the concept of continuity of care as it applies to persons with chronic psychiatric disabilities. It is this author's contention that if such a conceptualization of care-giving is present in the practice of psychiatric rehabilitation, the regrouping process can occur without bringing about additional stressors and setbacks for the patient/client and the helping person. We will now summarize Bachrach's seven dimensions:

1. Continuity of care has a longitudinal nature, and as such, anticipates and incorporates for the patient his or her needs for intermittent, short-term and longer-term elements of service which are not disconnected because of the nature of the patients' episodic illness.
2. Continuity of care is planned on an individual basis not as a function of the service delivery system into which groups of patients are then fit.
3. Continuity of care is comprehensive in nature and therefore is not the single domain of any single helping profession or support agency.
4. Continuity of care is a flexible process which accommodates the nonlinear progression of the psychiatrically disabled individual.
5. Continuity of care is characterized by the concept of a relationship and whether it be personal or institutional, that relationship means that the patient "is able to rely, over time, on having associations with a person or persons who are interested in him and who respond to him on a personal level" (Bachrach, p. 1451).
6. Continuity of care must incorporate the notion of accessibility in all of its meanings: physical environment, financial, psychological; when accessibility is hampered by the very nature of the person's disability, continuity of care will be predicated on the existence of an enabler who assists the person to gain access to the system.
7. Continuity of care implies and is contingent upon the existence of linkages in the system so that communication between the client and the service providers and among the service providers themselves does occur.

WORKING THE SYSTEM

Finally, we would like to add an eighth dimension to Bachrach's concept of care continuity. In many ways and perhaps even more so with the population of persons with psychiatric disabilities, the practitioner must learn to "work the system." A familiarity with the regulations, laws, entitlement programs, appeals process, etc., that affect the world of these consumers is essential for the rehabilitation practitioner. Even if the individual practitioner does not have a level of expertise in the area of legal rights, and/or requirements, knowing what questions to ask and where to turn for the answers are essential functions of the practitioner's role particularly in terms of regrouping. Outside of those individuals who work for one of the state offices of vocational rehabilitation, few practitioners, for example, are aware of Section 501 of The Rehabilitation Act of 1973 (PL 93-112) or Section 402 of The Veterans Readjustment Assistance Act (Cite), both of which provide for an affirmative action program affecting the mentally restored person or veteran. Section 501 deals particularly with Federal Government agencies and their hiring practices and allows for "two special hiring programs for 'mentally restored' individuals" (Russell & Pardes, 1981, p. 5). The role of the rehabilitation practitioner may vary in terms of the quality and quantity of activity levels throughout the rehabilitation process, but at no time is it more necessary to have a surge of energy and renewed commitment to the client than at times of regrouping. And needless to say, this renewed vigor must be accompanied by a sound and useful knowledge base of the systems, within and between which the goal of continuity of care for persons with psychiatric disabilities is either thwarted or accomplished.

CONCLUSION

In summary, the focus of this final chapter has been on the role of the rehabilitation practitioner in terms of: 1) expectancies of the system of service delivery and of the client; 2) the ongoing therapeutic relationship between the rehabilitation practitioner and his/her client; 3) the establishment of realistic and congruent goals with the consumer of services; 4) the setbacks in the rehabilitation process which are inherent in the treatment of a severe, chronic and episodic illness; 5) setbacks that result from the secondary gains which can be derived from the role of being a sick person and from those factors which lead to burnout on the part of the practitioner; and finally, 6) the necessity for a system of care continuity to insure the process of regrouping by the practitioner and the client with a psychiatric disability.

While the various authors who have presented materials in this text, based on their common and unique experiences in the field of psychiatric rehabilitation, do not propose to have all the answers, nor for that matter to have raised all of the possible questions and concerns of those in the field, they have attempted to deal with major areas of concern in a practical and forthright manner. So, too, this final chapter has been this author's perceptions and insights into the role of the rehabilitation practitioner. This role and its many and diverse functions mirror the complexities and subtleties, unknowns, working hypotheses, and research investigations about the disability itself which results from a psychiatric illness. We in the field must always be open to new knowledge, new ways of doing things, reexamining our current practices, and refining on a continuous basis our skills and abilities. We have no choice in this matter as the very fluid and individual nature of the disability with which we are concerned and the population of individuals which it affects demand such. Psychiatric rehabilitation, when all is said, is a challenge worthy of the commitment, energy, and skill of all who would work in this field.

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THE CONCEPT OF MENTAL ILLNESS AND ITS DIAGNOSIS

THE CONCEPT OF MENTAL ILLNESS AND ITS DIAGNOSIS

Lynda J. Katz, Ph.D.

Historically, the concept of mental illness has been derived from clinical work with individuals who have deviated to some degree from what society in general has regarded as normal or nonpathological behavior, both on an intrapersonal and interpersonal level. The meaning of mental illness, therefore, has been distilled from the theoretical notion of "abnormality," and operationalized across societies and eras in terms of its manifestations in major functions of living. The identification of persons with mental illness has been of concern over the years because of the enormous implications it has for public policy and decision making activities, particularly those concerned with resource allocation and the expenditure of public dollars. It has been estimated that, at a minimum, some two million persons in the United States can be considered to be chronically mentally ill (Goldman et al, 1981). Many have spent the majority of their lives in mental institutions, others have experienced repeated short term hospital stays while remaining in the community (Rutman, 1987). Psychiatric illness ranks fifth among major disease categories contributing to limitations in activity (Kottke et al, 1982), and of those nearly 1.5 million severely and moderately disabled persons with chronic mental illness who reside in the community, some 550,000 receive Supplemental Security Income (Anderson, 1982). Moreover, the number of individuals with psychiatric disabilities amount to nearly 40% of the state vocational rehabilitation agencies' caseloads, nationally, and at the same time, those with chronic and severe mental illness are the least successfully rehabilitated of all disability groups. It has been ascertained also that less than 15% of persons with severe psychiatric disabilities are successfully employed. Thus, decisions regarding the establishment of priorities (research vs. prevention vs. rehabilitation) and how initiatives under these various priorities will be financed will be directly influenced by the criteria selected to define mental illness and who will be identified as falling under those particular disease category criteria.

In order to understand how the concept of mental illness has been operationalized, it is useful to identify those specific criteria which have been utilized in the process. Scott (1958) summarized those criteria in his review of the field (see Table I below.) Thus, under the first criterion, exposure to psychiatric treatment, anyone who has sought mental health services might arbitrarily be included among those who would be identified under the category, mental illness. If the presence of a psychiatric diagnosis and objective psychological symptoms are the criteria utilized then the number of persons identified lessens and appears to rely heavily upon the medical profession to define the presence or absence of a disease process or illness. In like manner some define mental illness solely in terms of maladaptive social behaviors.

Table 1

Criteria of Mental Illness

Exposure to psychiatric treatment
Psychiatric diagnosis
Objective psychological symptoms
Social maladjustment
Failure of positive striving
Subjective unhappiness

Adapted from: Scott, W.A. (1958).

Still others view it as an intrapsychic phenomenon, i.e., anyone who is unhappy and experiences some kind of psychological difficulty inside him or herself might meet the defining and necessary criterion to be classified as mentally ill. The implication here is that each criterion provides a partial explanation and definition of the term mental illness.

Underlying these criteria of mental illness are four concepts of abnormality which derive from the fields of biological medicine, sociology, psychology, and statistics. Since the definition of mental illness comes from clinicians in an attempt to define current practice, what happens if mental illness is defined under one of these criteria separately? If the clinician's concept of abnormality is based on a biological model, then mental illness is seen as a symptom of an underlying physical abnormality. In this case mental illness would be diagnosed by physicians who work with persons who have physical illnesses and disorders. Implicit is the idea that illness is universal to mankind.

If abnormality is viewed from a sociocultural perspective, i.e., if the clinician believes that the only reason persons are mentally ill is because of poverty, then mental illness is not seen as resulting from an underlying biological dysfunction. Instead it is felt that if people were not so poor, if problems of early nutrition were addressed, or if persons were provided improved access to health care, then there would not be mental illness. The sociocultural concept of mental illness focuses on interpersonal and social behavior. In addition, deciding if particular symptoms are an expression of disease or illness implies a social value judgment. The definition of mental illness results from a judgment regarding the interaction of an individual with his or her environment. Therefore, those designated as having mental illness will vary from society to society and from era to era. Adjustment, then, is viewed as adherence to social norms. This concept of abnormality makes it difficult to distinguish between mental illness and social deviance or between insanity and criminality. People can commit a crime or break the law, that is, their thinking can deviate from social norms, and yet not have mental illness. Also, as Szasz (1969) has pointed out in his distinction between physical illness and the social role of the patient, within the sociocultural concept of mental illness a person can live and function normally or have nothing wrong and constantly seek help.

On the other hand, the theoretical bias might be that people, for whatever reason, become confused and distressed because they cannot come to grips with who they are and how they relate to the world. In this case, the clinician will stress that intervention takes place at the psychological intrapersonal level. And finally, if a person is interested in epidemiological research, policy administration, or the allocation of funds, he or she may have still another way of defining mental illness, i.e., a statistical or numbers model.

It is important to consider these underlying theoretical biases because they affect and often dictate approaches to treatment. If mental illness is viewed as resulting from social and environmental forces, then concerns will be directed toward changing policy issues, funding, and constraints on personal freedom rather than with the use of medication. The perspective taken by Thomas Szasz (Detre & Jarecki, 1971) illustrates an extreme example of this viewpoint. Although a psychiatrist himself, he takes a dim view of the profession. He believes that there is no biological basis for mental illness and that we label people because we do not know any other way of dealing with them. Others take an even more extreme view. Laing, an English psychiatrist, views the illness of schizophrenia as a form of creativity. He believes that, in fact, people are not ill at all, but that society has impeded the expression of their own uniqueness (Torrey, 1983).

The first two criteria in Table 1, exposure to psychiatric treatment and psychiatric diagnosis, would be of concern to those involved in epidemiological research or allocating resources. For instance, when studying the use of a particular drug, it is important to ensure that those for whom one drug has been prescribed all have the same diagnosis, based upon symptoms. Similarly, a study concerned with how many social workers, VR counselors, or doctors are needed in the country necessitates an overall sense of how many persons require service from such health professionals. Taken by itself, the first criterion, counseling by a psychiatrist or psychologist, is so broad an interpretation of mental illness that most of us would have problems with it.

Mental illness as defined by current psychiatric practice is a multivariant concept. As such there is no clear distinction between mental and physical illness. If such a distinction were to be made, mental illness might be defined as a value judgment regarding the need for corrective interventions, based upon both the qualitative and quantitative properties of the social and/or psychological characteristics of an individual in the absence of precipitating biophysical abnormalities. However, such a distinction is not justified if, indeed, there are mental illnesses which have a basis in physical abnormality. What we are saying, therefore, is that you can measure the degree of physical fitness, the degree of social adjustment, the degree of subjective distress, and also the degree of severity of distress and seriousness of an illness. So in order to decide whether behavior has some psychiatric significance we evaluate it in terms of three basic bodies of information: sociocultural (environmental), biological, and psychological. These three areas become the data base.

Environmental determinants of abnormal behavior can be considered at maturity or during development. At maturity, physical or psychological stress caused by life events, frustrations, conflicts, or pressures are thought by the proponents of this view to be causes of mental illness. Some suggest that moon phases, geomagnetic forces, or seasons of the year play a role in abnormality. Sociocultural considerations like urbanization, population density, social attitudes, social class, unemployment, and poverty are often cited as environmental determinants of abnormal behavior. During development, child rearing practices, mistiming of events, under- or over-exposure to necessary events, occurrence of unusual events, prenatal or postnatal events, emotional trauma during childhood, and social isolation at critical periods might all be considered determinants of abnormal behavior.

Psychologists and psychiatrists who adopt the biological concept of abnormality consider mental illness to be like any other illness. They characteristically assume that the primary cause of abnormal behavior is a defect or deficiency in the biological constitution of the individual.

Psychological theories, such as Freud's theory of psychoanalysis, the socially oriented theories of Adler, Fromm, and Sullivan, or Ellis' cognitively oriented theory all consider the primary cause of abnormal behavior to reside within the mind of the individual.

The mental illness of autism provides us with a good example of these three different theoretical biases and the data base from which they are derived. Autism was first described in 1943 by a psychiatrist, Kanner. Psychiatry in America at that time was bound by psychoanalytic thought. The psychiatric community concluded that autism was the result of a poor parent-child relationship. For whatever reason, a cold, rejecting mother was not able to make her child feel comfortable, loved, and warm. As a result, the child withdrew. (Keep in mind that under a medical model the cause of a disease is important because it can tell us something about how to treat the disease.) If autism is the result of an interpersonal distancing between mother and child (she did not love the child, so the child became cold and withdrawn), then the way to treat the autism is to put the mother in therapy. This helps the mother learn to be warm and loving. The child is also placed in play therapy so that he or she might learn how to become close to or fond of objects. Then, hopefully, the child will become more connected to people; and after 7 years of therapy for both mother and child, the disease is cured. Although this cure did not occur, the treatment continued to be viable for a long time; not out of maliciousness, but because that was all that was known about autism at the time.

The late 1950s and early 1060s brought the development of learning theory and the increased use of behavior therapy. In fact, psychologists so disillusioned with the current expensive but ineffective treatment methods began to suspect something was wrong with the psychoanalytic model. They theorized that autism was a learned response to the environment. Maybe indeed there was some coldness here, but the child learned it. They did not blame the mother anymore. Instead, psychologists suggested that for whatever reason -- maybe by virtue of biological makeup, maybe by virtue of circumstances at the time -- the child had not learned to be responsive. Therefore, the treatment approach was to teach responsiveness. Lovass and his colleagues (1965) began to do behavioral training: that is, teaching skills such as eye contact, how to verbalize, or to be comfortable with hugging. So here again, the treatment was based on the theoretical basis of the person doing the treatment. That behavior therapy was believed to work for a variety of disorders was based upon an underlying learning theory clinical orientation. Autism was seen as a learned response and the treatment involved relearning more appropriate behaviors.

It turns out that there was some success with this method. Lovass was able to demonstrate that behaviors could be taught but these behaviors were environmentally specific. That is, a child could be taught to attend to a task in the classroom; but if he or she were taken on a field trip, the skills did not generalize. Autism was neither cured nor was the cause discovered. The concern during this era, however, was with changing the behavior not with establishing cause.

This behavioral approach to treatment dominated the treatment of autism until the late 1960s and early 1970s. At that time another theoretical shift occurred in psychiatry and psychology. Professionals again became interested in the biological origins of behavior. Autism was classified as a developmental disability and researchers began to investigate the illness from a genetic perspective. They asked whether there might be some brain chemical, either absent or defective, that caused the illness. Autism, then began to be studied in this way. Because the patients could not generalize learned behaviors it was important to try to understand the nature of, and, if possible, establish the cause of the illness. Research took on a distinct biological perspective. At present there is much work being done with the use of various medications with autistic children because there is evidence to support the involvement of a metabolic or chemical imbalance in the disease process. The origin of some cases of autism have been traced to the Fragile X Syndrome.

At least one out of ten persons who are autistic have a disarranged chromosome, although that same chromosome is known to be responsible for the inheritance of other disorders as well.

What does this mean in terms of treatment? What does conceptualizing autism as a biological disorder have to do with the treatment of persons who have the illness? A great deal of effort is now going into prevention by isolation of the gene or chromosome that is responsible. Researchers are trying to find the source and alter it. At the very least, a prenatal diagnosis gives people an opportunity to decide whether or not they want to take the risk. There are many ramifications of the recent discoveries. They suggest that genetic engineering or a drug developed to affect an identified chemical imbalance might point to a different approach to the treatment of autism. At the same time, however, we have children with autism who still need to be taught, and so behavioral methods have not been discarded but rather incorporated into a multi-factorial view of the disease and its treatment.

DEFINITION OF MENTAL ILLNESS

Mental illness cannot be adequately defined from any one theoretical basis. In fact, mental illness is a complex of the biological basis of behavior, the environment in which the person exists, and the innerworkings of each person. Table 2 presents the definition of mental illness used for this discussion. First, in order for an individual to be diagnosed with a mental disorder there must be evidence of social dysfunction on the job, within the family, or in society. Secondly, there must be symptoms of psychological and biological discomfort; that is, distress, discomfort, and pain are involved. And third, it is inferred that disturbances in the mechanisms that regulate mood and cognition are the basis for the symptoms. This definition encompasses the lowest common denominator of agreement. It includes all those persons whose symptoms are so pronounced that almost any observer would agree they are dysfunctional but excludes those socially competent individuals with a character neurosis whose "illness" some clinicians would dispute.

Table 2

Definition of Mental Illness

1. Evidence of social dysfunctioning
2. Symptoms of psychological and biological discomfort
3. Disturbances in the mechanisms that regulate mood and cognition

Adapted from: Modern Psychiatric Treatment by Thomas P. Detre and Henry G. Jarecki, 1971.

Social dysfunction is probably the least controversial of these three criteria. Even if you do not accept the fact that most mental illness is the result of a biological dysfunction, most people will accept the fact that, if an individual is unable to function in society, he or she has a problem. Social functioning is the result of the complex interplay between an individual's biologic equipment, early life experiences and training, and a given situation at a particular point in time. Parents recognize early on that their infant children are not peas in a pod. Some are placid and quiet while others are irritable or cry for the first 6 months of life. Parts of the personality are present the day a child is brought home from the hospital. We all come into this world with certain traits. We either have good eyesight or we have poor eyesight. We have an easy disposition or we are sensitive and irritable. Next, all of us are exposed to environments that reinforce certain behaviors but not others. We learn to be aggressive and speak our minds or we learn to keep our mouth shut because it is safer. At some point in life we have to deal with crises and we each do this in particular ways. If we examine social dysfunctioning in depth, we find adaptational deficiencies. All of us come into this world with some things we do better than others. Generally in life, we prefer to put ourselves in situations in which we capitalize on what we do well and avoid those things that we don't do so well.

An individual's adaptational deficiencies determine which events are most likely to disturb him or her and influence the symptoms if he or she falls ill. If a client encounters a situation that requires him or her to react in a way he or she cannot, then the client is likely to become anxious and confused. The more urgent and prolonged the demand and the more poorly developed the biological capacities or social skills necessary for adequate response, the more severe the discomfort is likely to become. Moreover, once illness develops those social skills that were the most poorly established before becoming ill are usually the first to become impaired (Detre & Jarecki, 1971).

The following example illustrates this phenomenon. Alice is a young lady who grew up in an average American family, attended public school, and was an average student. There were never any problems; however, she was not a particularly outgoing person in her growing up years. She had several friends, not many, but was close with her family. Alice and the family did things together most of the time. She was active in the church and in a church social group, did not date often, and would be described in her school yearbook as "Miss Average - She will succeed."

After a few years of business school, Alice took a clerical job in a large company. The job entailed filing, typing, and self-directed work. There was not much contact with the public. She did not have to do a lot of emergency phone answering or handling crises. The work came in every day and she did it. At the end of the day the work was all done; that day's tasks complete. There was no disorder, things were filed, and the desk was cleared of work on a daily basis. Alice worked faithfully with no problems. She still lived at home, went out to dinner with the family, or occasionally would go out with a friend. Generally, she was a quiet person. Her work performance ratings were always excellent in terms of quality and productivity. She got along with everybody, never causing problems.

One day the chief executive officer's administrative secretary resigns. Since he is a good company person, he decides, "Before I go outside to look for another employee, I think I want to look at our work force, and maybe I can reward someone who has done an outstanding job. Maybe I will promote him or her to be my administrative assistant." He consults with personnel. They look at records, and, lo and behold, there is Alice. Everybody says, "This is a fine employee. The quality and quantity of work and ability to get along with her peers is excellent." She is offered the position. This is a promotion, a real honor, and she accepts.

Most of the time of the administrative assistant of a CEO is spent putting out fires, taking phone calls, placating irate people, scheduling meetings, and handling conflicts. Even if he/she is in the middle of typing a report, the work is put aside, the crisis handled, and the individual goes back to the interrupted task. So our Alice, then, in this new job, has had to give up her routine and orderly way of proceeding. Work starts to pile up as she tries to deal with phone calls, emergencies, conferences, travel arrangements, and unhappy clients.

Alice, like all of us, came into life with some assets and some deficits. Up to this point she has managed to capitalize on her assets. Her first job played on her strengths. She had organizational skills, perseverance, minded her own business, and did very well. Now, however, she is in a position that demands a change in her behavior. She must be extremely flexible, be willing to postpone things, stay after work, come in early, and get things done even though there is too little time. Alice's desk is never organized anymore. She is asked to exist in chaos and yet to be flexible. She must also do things that she has never really practiced much -- talk, be sociable, and smile constantly even if she does not feel like it.

In addition, Alice now has to make arrangements for just about everything. If the boss wants her to pick him up at the airport, she must drop everything and go. Throughout all of this, Alice is becoming anxious and somewhat confused. These feelings build as the situation continues. Some of the symptoms of stress are beginning to emerge. Alice stays later at work. By the time she gets home her stomach is so upset that she does not want to eat. The only thing she wants to do is go to her room. This behavior continues for the first week.

By the second week on the job she is not eating at all. She arrives at work at 5:00 in the morning, not leaving until 7:00 or 8:00 at night. She has no energy left; so even if she wanted to spiff herself up or look nice, she can't. It is all she can do to drag herself in every morning. Her family urges her to go out more. Alice responds, " I don't feel like going out, just leave me alone. You go. I just need to rest."

The third week goes by. She has lost about fifteen pounds and actually has no appetite. Her sleep is becoming disrupted. She is agitated, often pacing in her room at night. Formerly orderly and compulsive, it takes more energy to keep things in their place; a concern that is becoming more and more important to her. She neglects her appearance. In the morning she does not want to leave home and begins to call up and say, "I can't come into work. I'm ill this morning." She misses a day or two of work. When she gets back, things are piled up even higher because she has missed two days. She gets sick on the job, goes home, and decides, "I can't come in for the rest of the week." Finally, then, she does not want to leave her room. So she does not.

This is an example of the process of social dysfunctioning. To measure its severity one must decide whether or not existing limitations have become more pronounced, whether previous personality problems have become more evident, and whether the symptoms are more numerous or more bizarre. Alice did not really talk to people that much, but now she will not talk to anybody. She is staying in her room. Previous personality problems have escalated. She has lost fifteen pounds. She is not sleeping. She is pacing. She does not want to leave her room. She is doing nothing with the family, and is in danger of being fired from her job due to absenteeism. When someone is in that much distress and we judge the situation to be severe, the next question we ask is, "Must this person have treatment? Must we intervene?"

Treatment is mandated when an individual's illness weakens his or her impulse control, manifests itself in catastrophic social dysfunctioning, is marked by major disturbances in biologic functions, or when one or more of these factors are persistent in time or are progressive in severity. When a person's psychological discomfort endangers his or her life or that of others, or paralyzes his social functioning, treatment is mandatory. Otherwise, it is not.

Exercise 1: What Would You Say About Alice?

Keeping these things in mind, refer to Table 2. Social dysfunctioning is one of the parameters of mental illness that can be observed. Nobody has to infer it. We do not always have to intervene, however, when persons are under stress. Knowing what you do about Alice, would you be comfortable saying that she meets the definition of mental illness presented?

Here are two scenarios. Scenario one: A month has gone by. Now Alice will not leave her room. The family is so distraught that they call the minister with whom Alice has been close all these years. They say, "Please talk to her. We do not know what else to do. Please talk to her."

The minister, who has training as a pastoral counselor, comes and engages her in conversation; Alice cries and tells him what is going on. They work through it. He reminds her, "Well, there are other ways to get promoted. I know you want everybody to be proud of you, but you were doing a wonderful job until you changed positions."

She dries her eyes and agrees, "You're right. I'm going to go back, and I'm going to ask to go back to my old job. Or I'll just get a job someplace else. Maybe I'd like to continue to talk to you."

Scenario two: The minister comes and goes through this same process, but with no impact whatsoever. Alice does not talk. She just cries, wrings her hands, paces the room off and on but does not talk.

Now, given those two sorts of outcomes, would one of those make you more comfortable in saying that she meets the criteria for the definition of mental illness presented? The point is that sometimes it is difficult within given circumstances to distinguish the difference between a transitory adjustment reaction to a stressor and mental illness. The variables that are probably most important in this determination are those of severity and duration. First, how severe are the symptoms; second, how long do they persist? Is there deterioration of biological functions that are life-threatening or at the very least, harmful to physical health with no relief or remission in sight? If so, we can be fairly sure that we are dealing with mental illness.

Now you can make some speculations and test your hypothesis. The minister tried talking to her. It did not do any good. Alice did not improve. Next, it may be that her family takes her to a psychiatrist who takes a history and prescribes medication. When a client is in need of sustained biological interventions, you have further evidence that the episode is not transitory, reactionary, and will not respond solely to psychological interventions.

Persons who are seen as suffering from a severe mental illness are not those with adjustment disorders or those having an adverse reaction to stress. The persons we work with in the vocational rehabilitation system are those who, for some reason, have very real and sustained functional limitations which result in their inability to adequately evaluate their own strengths and assets; they have never developed coping mechanisms; and their pattern of social dysfunctioning has continued for many years.

THE USE OF DIAGNOSIS

Ultimate proof that psychopathology exists must lie in the successful treatment of abnormal behavior. In medical specialties generally, successful treatment is considered to be dependent upon the recognition of the cause of the disease or illness under study. Before looking for a cause of a particular dysfunction or disorder, that dysfunction or disorder must be isolated, however crudely, and it must be recognized and differentiated from other symptoms. This effort has led to the classification of mental illnesses or the identification of different types of diseases and disorders and their relationships to each other. Classification involves a logical way of putting together the symptoms to help us decide exactly with what syndrome or group of symptoms we are dealing. We do this so that we know what to do about the symptoms and so that we can predict the course of the illness, response to treatment, and which intervention strategies might be most effective. Diagnoses or classifications are not negative data but rather they provide a basis for better educated understanding of individuals who present with specific symptoms. For instance, if we take someone into a rehabilitation setting who has a cyclical illness, we have to build that fact into the rehabilitation plan. Recurring illness does not have to be seen as failure.

A way to classify diseases and symptoms is necessary to insure that all professionals are talking about the same thing. If I say this person has schizophrenia, you all would know and agree, as much as possible, that this was true. Why is that important? It is important because if the client were on inappropriate medication or none at all, it would have dire consequences to his or her functioning. If the client does not understand his or her illness, this also could have serious implications. The diagnosis tells something about the coping mechanisms of the client and what kind of support systems have to be built into the rehabilitation process. If the counselor knows that there is the potential for impaired judgment to exist in persons with schizophrenia, or that these persons might have problems confiding in others or using support groups, then they can apply this knowledge in terms of rehabilitation planning.

What is classification then? It is the process of reducing complex phenomena by arranging them into categories according to some pre-established criteria. The classification of mental illness can be seen as a filing system for the easy handling of data, as a means of facilitating communication among professions, and as a means of labeling entities to establish categories and to unify certain relationships among different categories. In psychiatry, such

THE DSM-IV DIAGNOSTIC SYSTEM

Lynda J. Katz, Ph.D.

Diagnostic and Statistical Manual, Fourth Edition, (DSM-IV), is one of the two major classification systems used today. The other is the ICD-9-CM, the International Classification of Diseases, 9th Revision, Clinical Modification. While the DSM-IV is not a Bible, so to speak, it is a useful tool; and its revisions since 1979 (DSM-III) speak to the dynamic nature of the diagnostic process. It is helpful in enabling us to conceptualize mental disorders in order to proceed with appropriate treatment interventions.

The DSM-IV like its predecessors, DSM-III and DSM-III-R, is based on a five-axial model of diagnosis, a model which attempts to bring together all of the theoretical concepts discussed previously regarding our understanding of mental disorders. Since there is no etiological position adopted with the Manual, persons who are either dynamically, biologically, or behaviorally trained can still agree on the diagnositc formulations contained therein.

The definition of a mental disorder contained in the DSM-IV remains the same as that presented earlier. Specifically, each of the mental disorders is conceptualized as:

(1) a clinically significant behavioral or psychological syndrome
(2) that occurs in an individual

(3) which is associated with present distress or disability or with significantly increased risk of death, pain, disability or an important loss of freedom
(4) not merely an expectable and culturally sanctioned response
(5) a manifestation of a behavioral, psychological or biological dysfunction, whatever its original cause
(6) not merely a conflict with society (1994, p. xxi-xxii).

Hence, the five axes of the DSM-IV present a compromise statement that infers dysfunction in one or more areas. A mental disorder is associated with distress or disability. Why the "or"? Because, a person could have a bipolar disorder, manic episode, and hardly be distressed. Most people who are in a state of mania are really quite happy to be there. It is fun for a time to be euphoric and on top of the world. We can hardly call that distress; but in fact, it is a disability in the sense that running out and charging $10,000, making inappropriate statements on the job, or being overly aggressive could get the person in trouble. The criterion "not only a conflict with society" addresses those cultures that label persons as crazy or deviant if they do not go along with or accept the prevailing social ideology (previous Soviet Union, as an example). There was an awareness that persons who differed from the mainstream might be labeled as mentally ill. Finally, a mental disorder occurs in individuals, not in groups, as in group hysteria or in a particular religious cult. If we are going to use the label mental disorder, the DSM-IV requires that it must occur in individuals.

The definition of mental illness is on the one hand very inclusive and, on the other hand, very exclusive. If you look at those criteria listed previously, you can understand why homosexuality or an alternative lesbian life style, once considered to be mental disorders, can no longer be classified as such. They do not meet the criteria. Homosexuality does not have to be associated with distress, and it certainly does not have to cause a disability. So in DSM-IV as in DSM-III and DSM-III-R, homosexuality does not meet criteria for inclusion into the diagnostic manual as it did in DSM-II.

On the other hand, learning disabilities were not previously considered to be mental disorders. Now, why were they added? The diagnosis of a specific learning disability in no way conflicts with the criteria used to define a mental disorder. Persons who work with children and childhood illnesses were very much concerned that learning disabilities be included in the Diagnostic Manual. Giving this disability a medical diagnosis recognizes it as a legitimate disability. In terms of the rehabilitation system, that legitimacy has significant consequences for service delivery. Before LD was recognized by DSM-III, it was not considered a medical disability by the Rehabilitation Services Administration. In 1980, after it was incorporated into DSM-III, it was then considered by RSA as a legitimate medical diagnosis in terms of eligibility for VR services.

The DSM-IV is based on a multiaxial model that is concerned with five major categories of assessment:

Axis I	Clinical Disorders Other Conditions that may be a focus of clinical

	attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

In the words of the DSM-IV: "The use of the multiaxial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and evironmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem" (p.25). It is recognized that having a psychiatric disability or disorder does not preclude a physical illness. The staff in general hospital emergency rooms have often told perons with a psychiatric history "There's nothing wrong with you. It's in your head. Go home". In reality, some persons with chronic mental disorders show a high incidence of physical disorders.

Axis I and II. Axis I and II comprise the entire classification of known mental disorders. All mental disorders except personality disorders and mental retardation are listed on Axis I. These are noted on Axis II so that their presence might not be "overlooked when attention is directed to the usually more florid Axis I disorders" (p. 26).

Multiple diagnoses are allowed. In other words, a person could have several diagnoses under one axis, with the principle diagnosis generally listed first. Provisional diagnoses can be made; the clinician is permitted to say, "I'm not sure. I think this might be the case." Usually, admitting to unsureness is the safest route. In addition, there are provisions for specifying the severity and course of the various disorders and whether they are recurring.

Axis III. This axis includes any current general medical condition relevant to the understanding or management of the individual. These medical conditions do not have to be related to the psychiatric disorder (but some may be), but they are relevant to the treatment of the person. When a mental disorder is judged to be "a direct physiological consequence of the medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the general medical condition should be recorded on both Axis I and Axis III" (p.27).

If a patient/client has schizophrenia and diabetes, it is extremely important to know that in terms of their treament. We know, for example, that drug metabolism is highly effected by general body metabolism and that noncompliance with medications is often a problem among individuals affected by the negative effects of a schizophrenic disorder.

Axis IV. Psychosocial stressors are addressed here. Psychosocial stressors may affect the diagnosis, treatment and prognosis of mental disorders. "A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed" (p. 29, DSM-IV). When, on the other hand, the psychosocial or environmental problem is the primary focus of clinical attention, it is also recorded on Axis I with a code derived from the section of the DSM-IV manual dealing with "Other Conditions That May Be a Focus of Clinical Attention"(P. 675).

Determining how to proceed with treament interventions for Axis IV problems may well involve determining the chronic vs acute nature of the problem as well. For example, an unemployed male client might talk about his other problems. He might say, "Yesterday, I was living in a supervised apartment. I got in a fight with my roommate and I was told that I have to be out of my apartment by Friday". He continues, "Before I became ill, you know, before I had to be hospitalized, I was married and I have kids. My visitation rights were taken away because I was abusive, but I'd like to be able to get to see my kids again. It's important to me. My wife keeps fighting me on this in court". If a clinician were trying to determine what to attend to first, he/she could weigh the chronic vs acute nature of the stressors and then proceed with an action plan. In this case, the first concern would be with housing.

Axis V. The clinician assesses the client's psychological, social, personal, and occupational functioning on Axis V in terms of overall level of functioning. The Global Assessment of Functioning Scale (GAF) is used for this purpose. This instrument can be used to rate the individual's current level of functioning at the time treatment is initiated and then later at discharge. It can also be used as a measure of premorbid functioning as one prognostic indicator. A copy of the GAF Scale is attached.

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Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(**Note:** Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 81	**Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members)
80 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork)
70 61	**Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 51	**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers)
50 41	**Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job)
40 31	**Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school)
30 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends)
20 11	**Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute)
10 1	**Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
0	Inadequate information

The rating of overall psychological functioning on a scale of 0–100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407–417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766–771, 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

Examples of How to Record Results of a DSM-IV Multiaxial Evaluation

Example 1:

Axis I	296.23	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
	305.00	Alcohol Abuse
Axis II	301.6	Dependent Personality Disorder Frequent use of denial
Axis III		None
Axis IV		Threat of job loss
Axis V	GAF = 35	(current)

Example 2:

Axis I	300.4	Dysthymic Disorder
	315.00	Reading Disorder
Axis II	V71.09	No diagnosis
Axis III	382.9	Otitis media, recurrent
Axis IV		Victim of child neglect
Axis V	GAF = 53	(current)

Example 3:

Axis I	293.83	Mood Disorder Due to Hypothyroidism, With Depressive Features
Axis II	V71.09	No diagnosis, histrionic personality features
Axis III	244.9	Hypothyroidism
	365.23	Chronic angle-closure glaucoma
Axis IV		None
Axis V	GAF = 45	(on admission)
	GAF = 65	(at discharge)

Example 4:

Axis I	V61.1	Partner Relational Problem
Axis II	V71.09	No diagnosis
Axis III		None
Axis IV		Unemployment
Axis V	GAF = 83	(highest level past year)

Appendix A

Decision Trees for Differential Diagnosis

The purpose of these decision trees is to aid the clinician in understanding the organization and hierarchical structure of the DSM-IV Classification. Each decision tree starts with a set of clinical features. When one of these features is a prominent part of the presenting clinical picture, the clinician can follow the series of questions to rule in or rule out various disorders. Note that the questions are only approximations of the diagnostic criteria and are not meant to replace them.

The Psychotic Disorders decision tree is the only one that contains disorders that are mutually exclusive (i.e., only one disorder from that section can be diagnosed in a given individual for a particular episode). For the other decision trees, it is important to refer to the individual criteria sets to determine when more than one diagnosis may apply.

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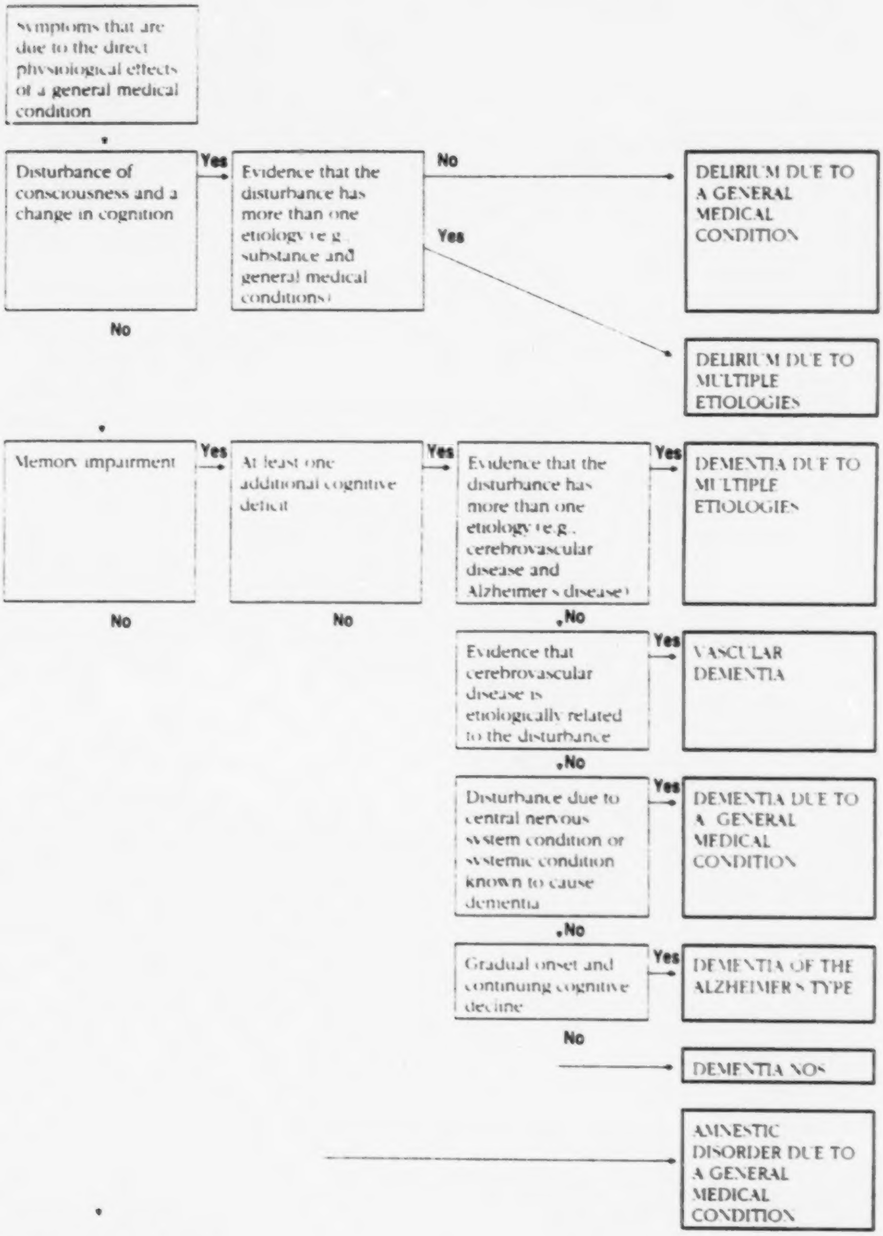
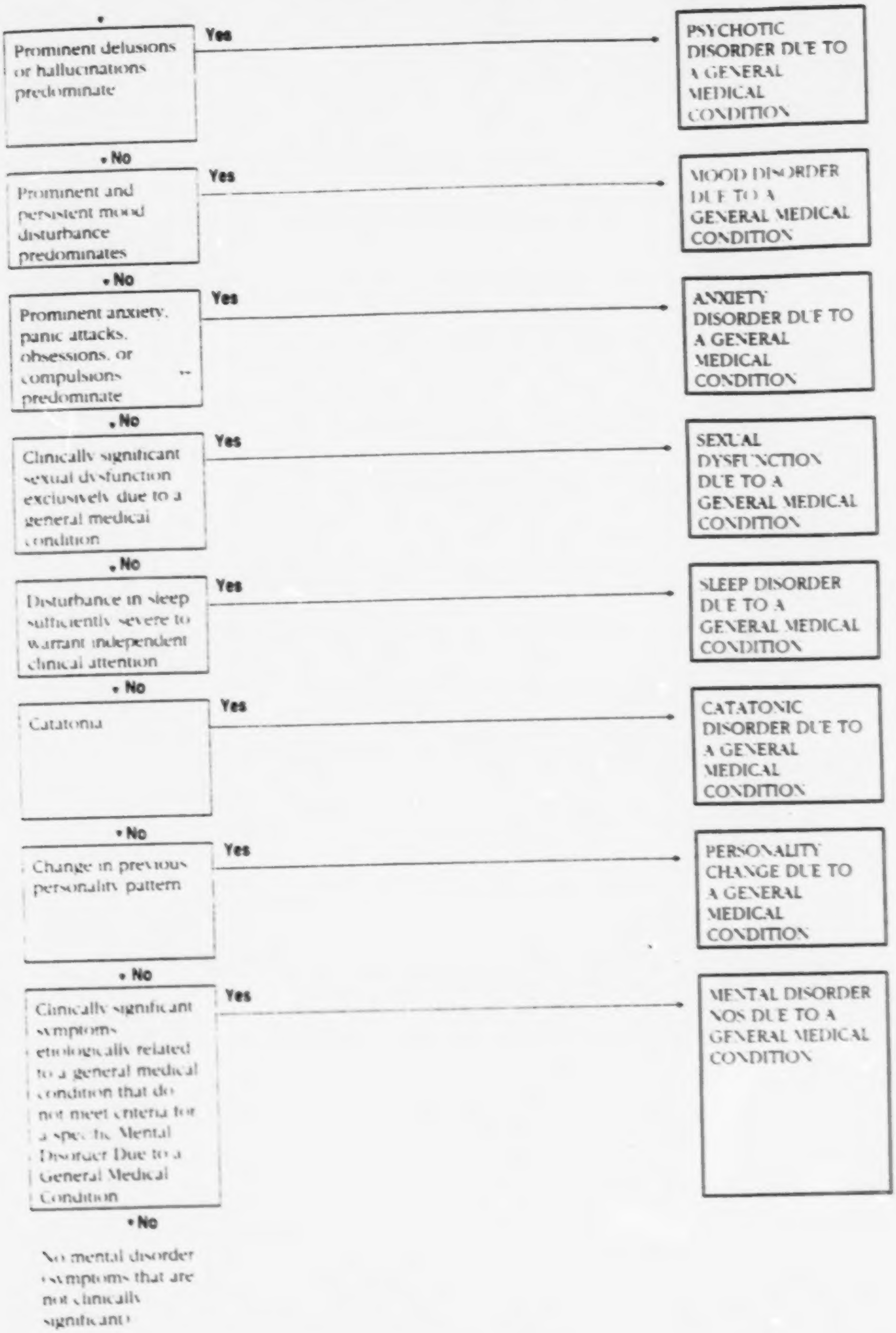
VI Differential Diagnosis of Somatoform Disorders 700

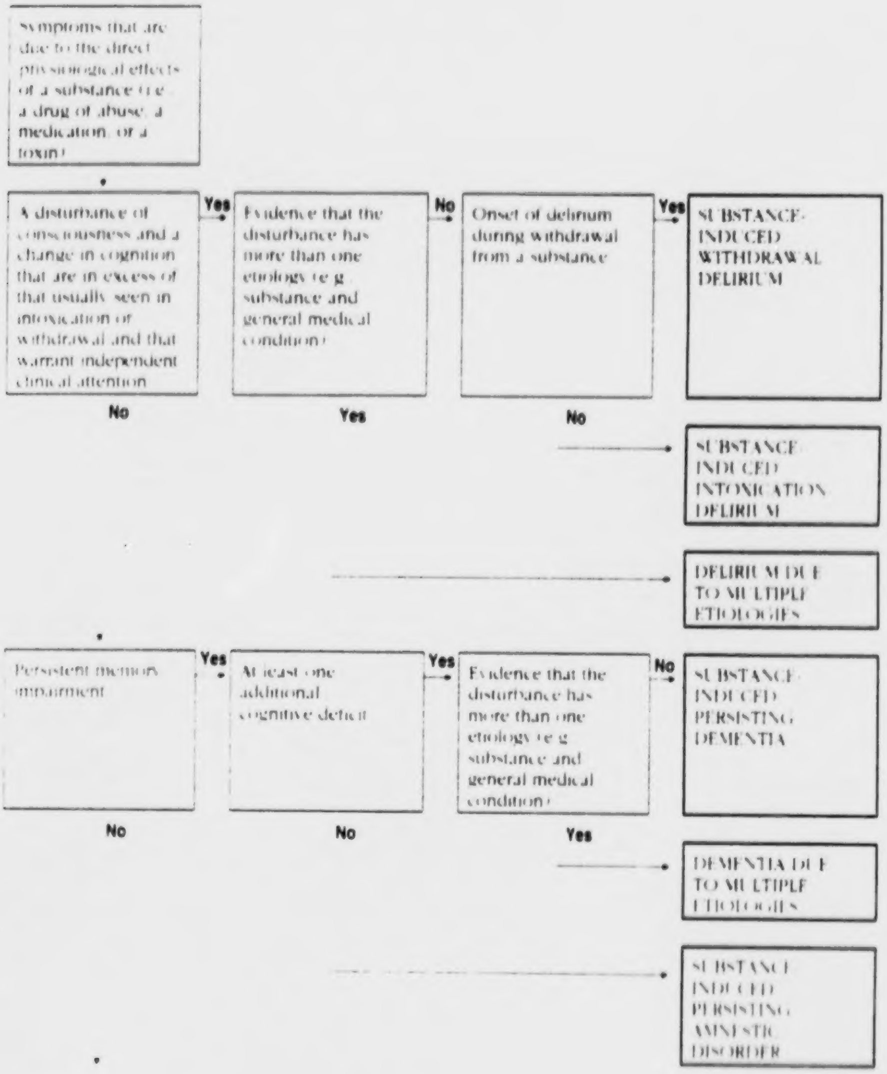
Note: Prepared by Michael B. First, M.D., Allen Frances, M.D., and Harold Alan Pincus, M.D.

Differential Diagnosis of Mental Disorders Due to a General Medical Condition


Symptoms that are due to the direct physiological effects of a general medical condition
Disturbance of consciousness and a change in cognition
Yes
Evidence that the disturbance has more than one etiology (e.g., substance and general medical conditions)
No
DELIRIUM DUE TO A GENERAL MEDICAL CONDITION
Yes
DELIRIUM DUE TO MULTIPLE ETIOLOGIES
No
Memory impairment
Yes
At least one additional cognitive deficit
Yes
Evidence that the disturbance has more than one etiology (e.g., cerebrovascular disease and Alzheimer's disease)
Yes
DEMENTIA DUE TO MULTIPLE ETIOLOGIES
No
No
No
Evidence that cerebrovascular disease is etiologically related to the disturbance
Yes
VASCULAR DEMENTIA
No
Disturbance due to central nervous system condition or systemic condition known to cause dementia
Yes
DEMENTIA DUE TO A GENERAL MEDICAL CONDITION
No
Gradual onset and continuing cognitive decline
Yes
DEMENTIA OF THE ALZHEIMER'S TYPE
No
DEMENTIA NOS
AMNESTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION


Prominent delusions or hallucinations predominate
Yes
PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Prominent and persistent mood disturbance predominates
Yes
MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Prominent anxiety, panic attacks, obsessions, or compulsions predominate
Yes
ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Clinically significant sexual dysfunction exclusively due to a general medical condition
Yes
SEXUAL DYSFUNCTION DUE TO A GENERAL MEDICAL CONDITION
No
Disturbance in sleep sufficiently severe to warrant independent clinical attention
Yes
SLEEP DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Catatonia
Yes
CATATONIC DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Change in previous personality pattern
Yes
PERSONALITY CHANGE DUE TO A GENERAL MEDICAL CONDITION
No
Clinically significant symptoms etiologically related to a general medical condition that do not meet criteria for a specific Mental Disorder Due to a General Medical Condition
Yes
MENTAL DISORDER NOS DUE TO A GENERAL MEDICAL CONDITION
No
No mental disorder (symptoms that are not clinically significant)

Differential Diagnosis of Substance-Induced Disorders (Not Including Dependence and Abuse)


Symptoms that are due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or a toxin)
A disturbance of consciousness and a change in cognition that are in excess of that usually seen in intoxication or withdrawal and that warrant independent clinical attention
Yes
Evidence that the disturbance has more than one etiology (e.g., substance and general medical condition)
No
Onset of delirium during withdrawal from a substance
Yes
SUBSTANCE-INDUCED WITHDRAWAL DELIRIUM
No
Yes
No
SUBSTANCE-INDUCED INTOXICATION DELIRIUM
DELIRIUM DUE TO MULTIPLE ETIOLOGIES
Persistent memory impairment
Yes
At least one additional cognitive deficit
Yes
Evidence that the disturbance has more than one etiology (e.g., substance and general medical condition)
No
SUBSTANCE-INDUCED PERSISTING DEMENTIA
No
No
Yes
DEMENTIA DUE TO MULTIPLE ETIOLOGIES
SUBSTANCE-INDUCED PERSISTING AMNESTIC DISORDER

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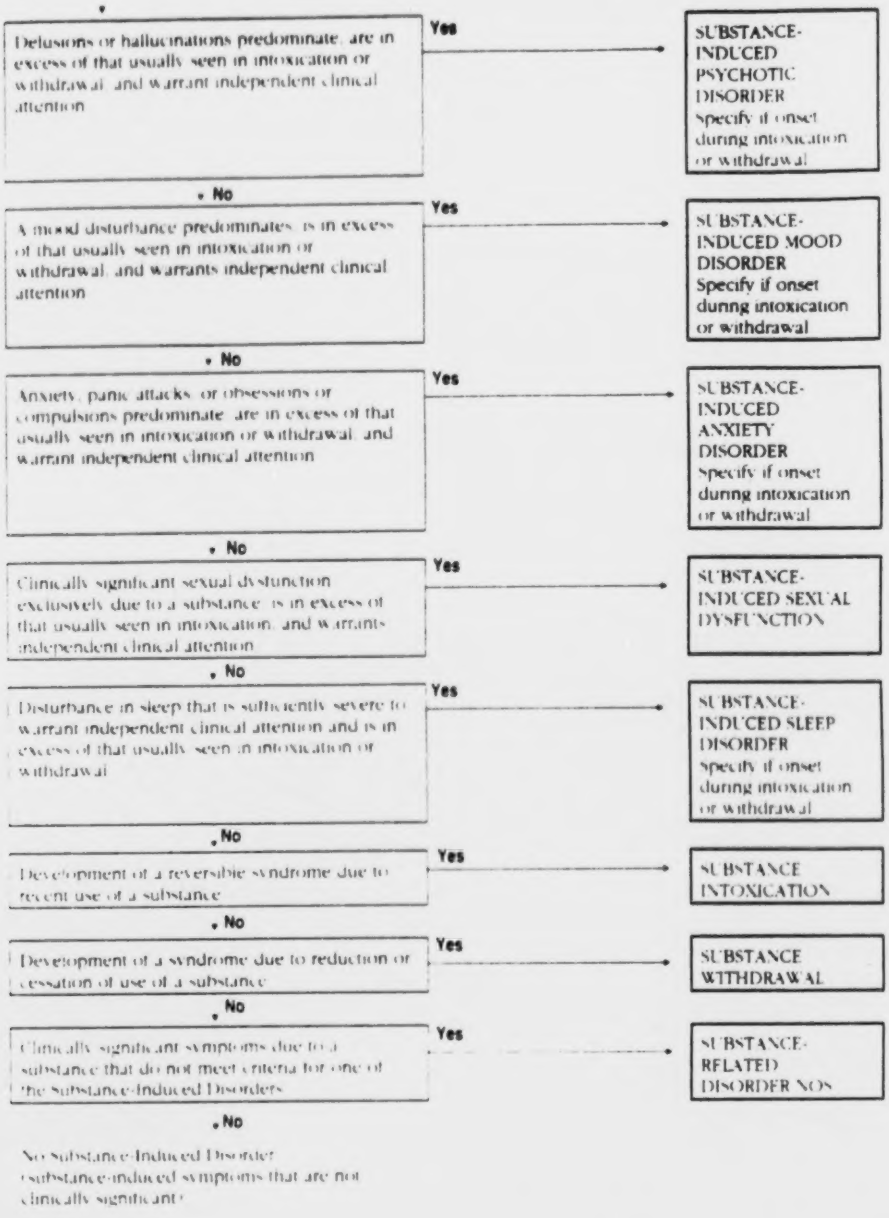


Delusions or hallucinations predominate, are in excess of that usually seen in intoxication or withdrawal, and warrant independent clinical attention

SUBSTANCE-INDUCED PSYCHOTIC DISORDER
Specify if onset during intoxication or withdrawal

A mood disturbance predominates, is in excess of that usually seen in intoxication or withdrawal, and warrants independent clinical attention

SUBSTANCE-INDUCED MOOD DISORDER
Specify if onset during intoxication or withdrawal

Anxiety, panic attacks, or obsessions or compulsions predominate, are in excess of that usually seen in intoxication or withdrawal, and warrant independent clinical attention

SUBSTANCE-INDUCED ANXIETY DISORDER
Specify if onset during intoxication or withdrawal

Clinically significant sexual dysfunction exclusively due to a substance, is in excess of that usually seen in intoxication, and warrants independent clinical attention

SUBSTANCE-INDUCED SEXUAL DYSFUNCTION

Disturbance in sleep that is sufficiently severe to warrant independent clinical attention and is in excess of that usually seen in intoxication or withdrawal

SUBSTANCE-INDUCED SLEEP DISORDER
Specify if onset during intoxication or withdrawal

Development of a reversible syndrome due to recent use of a substance

SUBSTANCE INTOXICATION

Development of a syndrome due to reduction or cessation of use of a substance

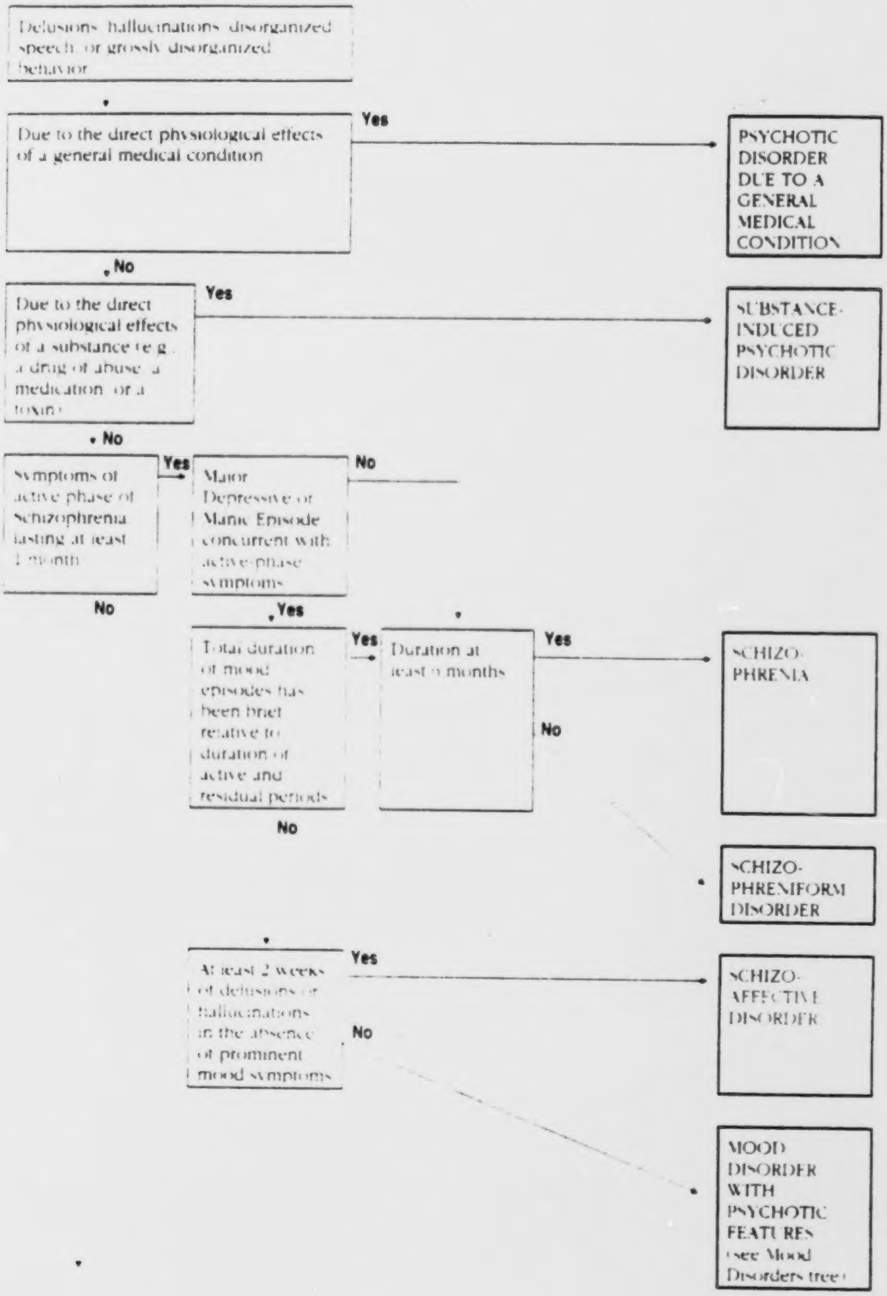
SUBSTANCE WITHDRAWAL

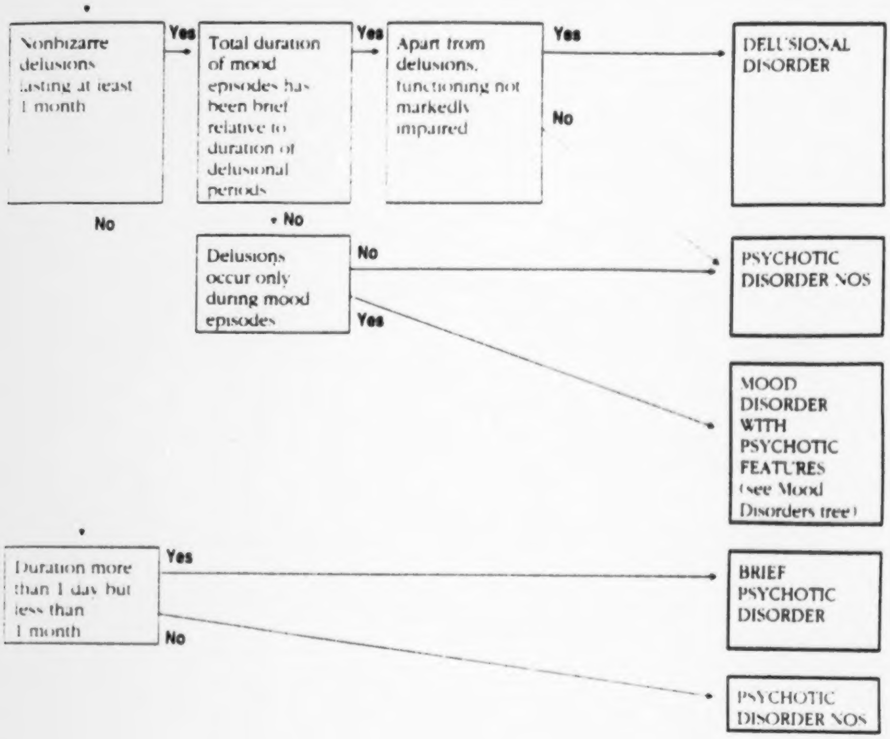
Clinically significant symptoms due to a substance that do not meet criteria for one of the Substance-Induced Disorders

SUBSTANCE-RELATED DISORDER NOS

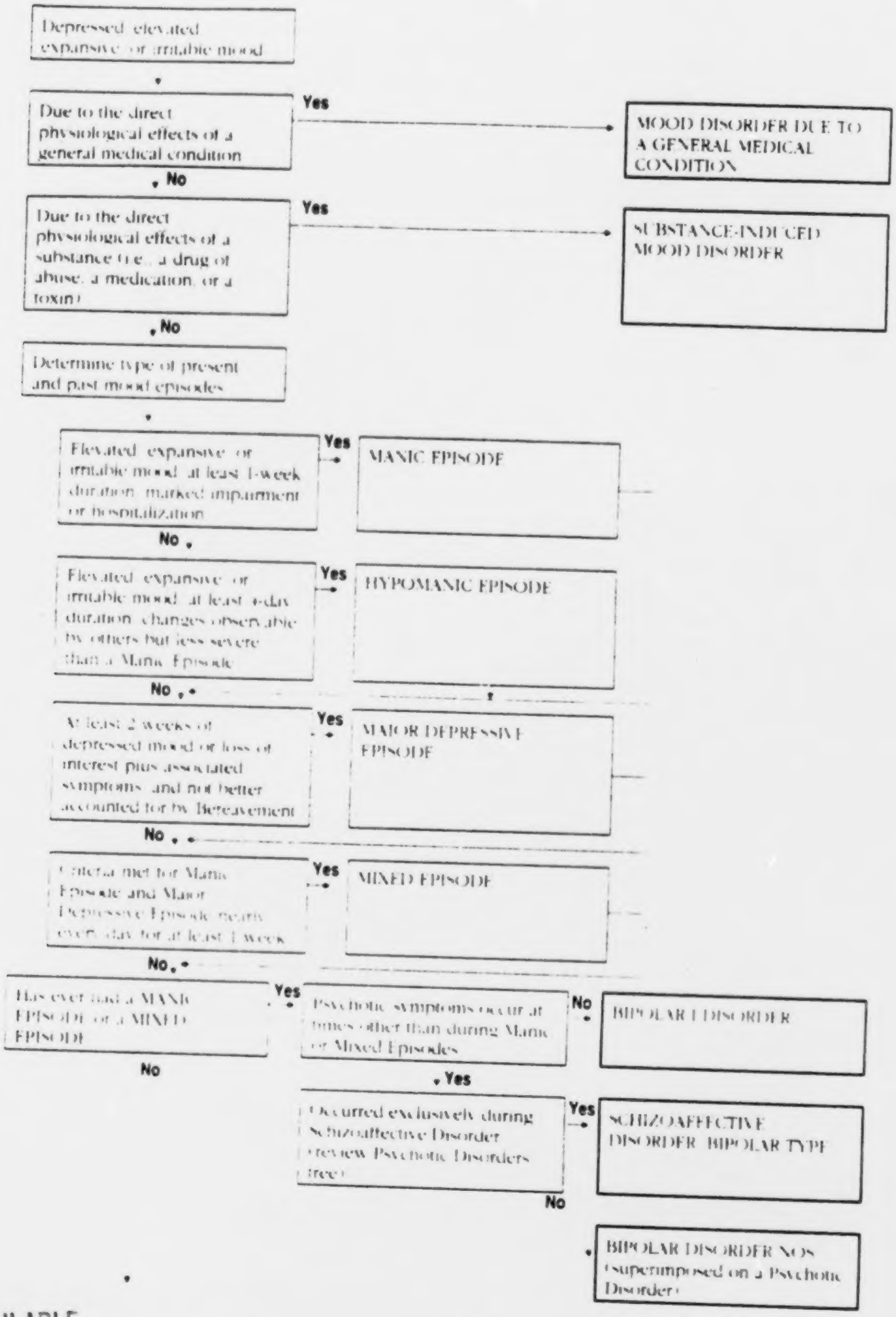
No Substance-Induced Disorder (substance-induced symptoms that are not clinically significant)

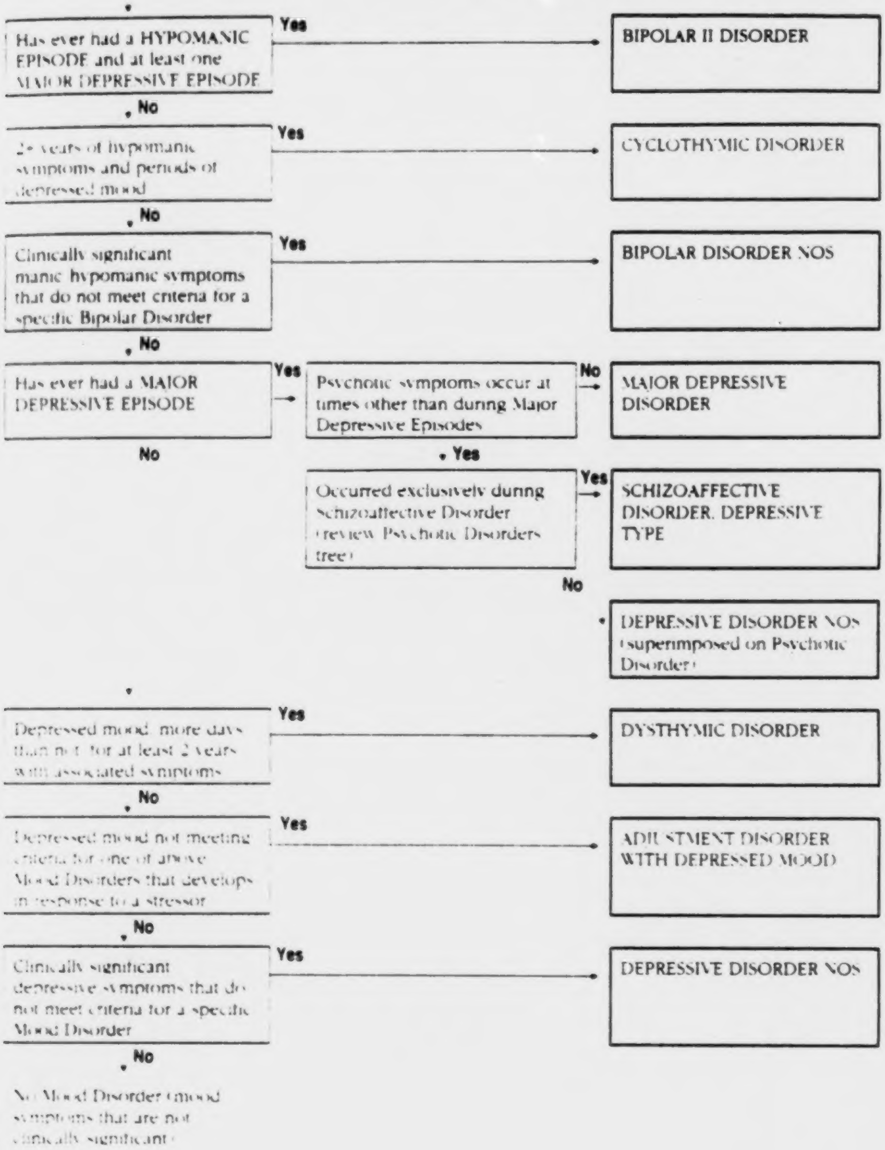
Differential Diagnosis of Psychotic Disorders


Delusions, hallucinations, disorganized speech, or grossly disorganized behavior
Due to the direct physiological effects of a general medical condition
Yes
PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or a toxin)
Yes
SUBSTANCE-INDUCED PSYCHOTIC DISORDER
No
Symptoms of active phase of Schizophrenia lasting at least 1 month
Yes
Major Depressive or Manic Episode concurrent with active-phase symptoms
No
No
Yes
Total duration of mood episodes has been brief relative to duration of active and residual periods
Yes
Duration at least 6 months
Yes
SCHIZOPHRENIA
No
SCHIZOPHRENIFORM DISORDER
No
At least 2 weeks of delusions or hallucinations in the absence of prominent mood symptoms
Yes
SCHIZOAFFECTIVE DISORDER
No
MOOD DISORDER WITH PSYCHOTIC FEATURES (see Mood Disorders tree)

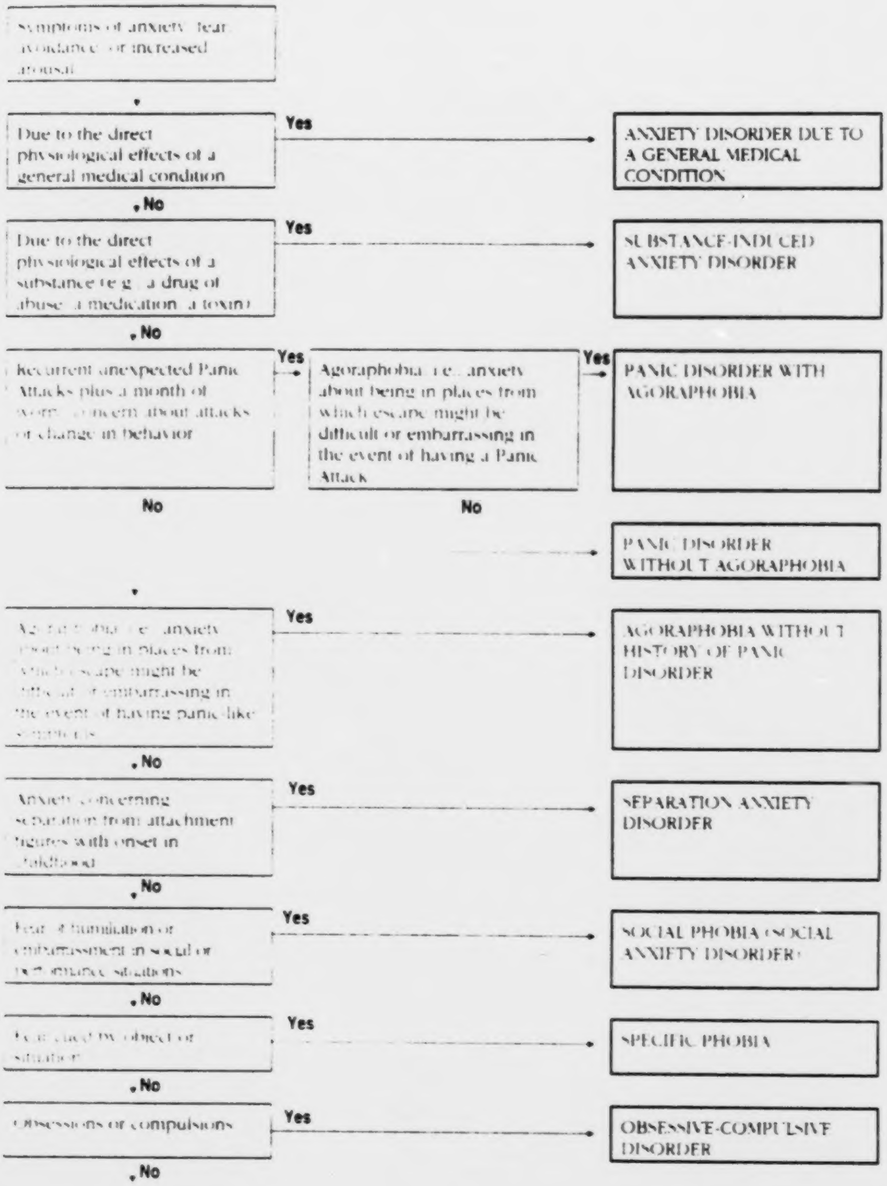

Nonbizarre delusions lasting at least 1 month
Yes
Total duration of mood episodes has been brief relative to duration of delusional periods
Yes
Apart from delusions, functioning not markedly impaired
Yes
DELUSIONAL DISORDER
No
No
No
Delusions occur only during mood episodes
No
PSYCHOTIC DISORDER NOS
Yes
MOOD DISORDER WITH PSYCHOTIC FEATURES (see Mood Disorders tree)
Duration more than 1 day but less than 1 month
Yes
BRIEF PSYCHOTIC DISORDER
No
PSYCHOTIC DISORDER NOS

Differential Diagnosis of Mood Disorders


Depressed, elevated, expansive, or irritable mood
Due to the direct physiological effects of a general medical condition
Yes
MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or a toxin)
Yes
SUBSTANCE-INDUCED MOOD DISORDER
No
Determine type of present and past mood episodes
Elevated, expansive, or irritable mood, at least 1-week duration, marked impairment or hospitalization
Yes
MANIC EPISODE
No
Elevated, expansive, or irritable mood, at least 4-day duration, changes observable by others but less severe than a Manic Episode
Yes
HYPOMANIC EPISODE
No
At least 2 weeks of depressed mood or loss of interest plus associated symptoms, and not better accounted for by Bereavement
Yes
MAJOR DEPRESSIVE EPISODE
No
Criteria met for Manic Episode and Major Depressive Episode nearly every day for at least 1 week
Yes
MIXED EPISODE
No
Has ever had a MANIC EPISODE or a MIXED EPISODE
Yes
Psychotic symptoms occur at times other than during Manic or Mixed Episodes
No
BIPOLAR I DISORDER
Yes
Occurred exclusively during Schizoaffective Disorder (review Psychotic Disorders tree)
Yes
SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE
No
BIPOLAR DISORDER NOS (superimposed on a Psychotic Disorder)
No


Has ever had a HYPOMANIC EPISODE and at least one MAJOR DEPRESSIVE EPISODE
Yes
BIPOLAR II DISORDER
No
2+ years of hypomanic symptoms and periods of depressed mood
Yes
CYCLOTHYMIC DISORDER
No
Clinically significant manic hypomanic symptoms that do not meet criteria for a specific Bipolar Disorder
Yes
BIPOLAR DISORDER NOS
No
Has ever had a MAJOR DEPRESSIVE EPISODE
Yes
Psychotic symptoms occur at times other than during Major Depressive Episodes
No
MAJOR DEPRESSIVE DISORDER
No
Yes
Occurred exclusively during Schizoaffective Disorder (review Psychotic Disorders tree)
Yes
SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE
No
DEPRESSIVE DISORDER NOS (superimposed on Psychotic Disorder)
Depressed mood, more days than not, for at least 2 years with associated symptoms
Yes
DYSTHYMIC DISORDER
No
Depressed mood not meeting criteria for one of above Mood Disorders that develops in response to a stressor
Yes
ADJUSTMENT DISORDER WITH DEPRESSED MOOD
No
Clinically significant depressive symptoms that do not meet criteria for a specific Mood Disorder
Yes
DEPRESSIVE DISORDER NOS
No
No Mood Disorder (mood symptoms that are not clinically significant)

Differential Diagnosis of Anxiety Disorders


Symptoms of anxiety (fear, avoidance, or increased arousal)
Due to the direct physiological effects of a general medical condition
Yes
ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION
No
Due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, a toxin)
Yes
SUBSTANCE-INDUCED ANXIETY DISORDER
No
Recurrent unexpected Panic Attacks plus a month of worry, concern about attacks or change in behavior
Yes
Agoraphobia, i.e., anxiety about being in places from which escape might be difficult or embarrassing in the event of having a Panic Attack
Yes
PANIC DISORDER WITH AGORAPHOBIA
No
No
PANIC DISORDER WITHOUT AGORAPHOBIA
Agoraphobia, i.e., anxiety about being in places from which escape might be difficult or embarrassing in the event of having panic-like symptoms
Yes
AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER
No
Anxiety concerning separation from attachment figures with onset in childhood
Yes
SEPARATION ANXIETY DISORDER
No
Fear of humiliation or embarrassment in social or performance situations
Yes
SOCIAL PHOBIA (SOCIAL ANXIETY DISORDER)
No
Fear cued by object or situation
Yes
SPECIFIC PHOBIA
No
Obsessions or compulsions
Yes
OBSESSIVE-COMPULSIVE DISORDER
No

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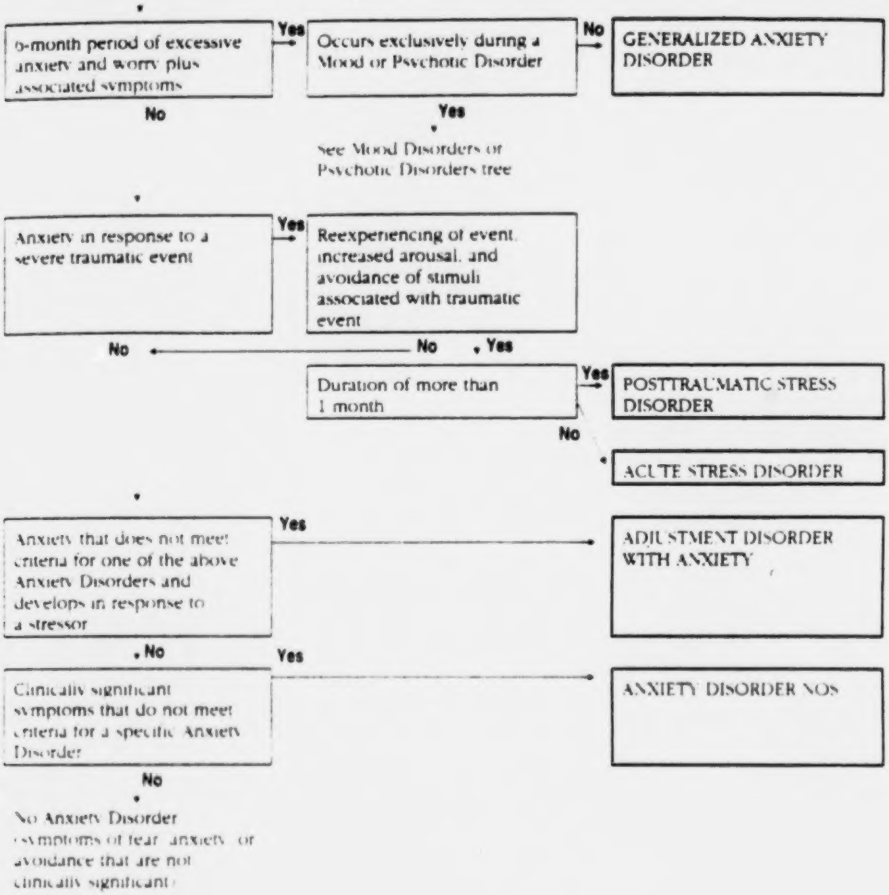
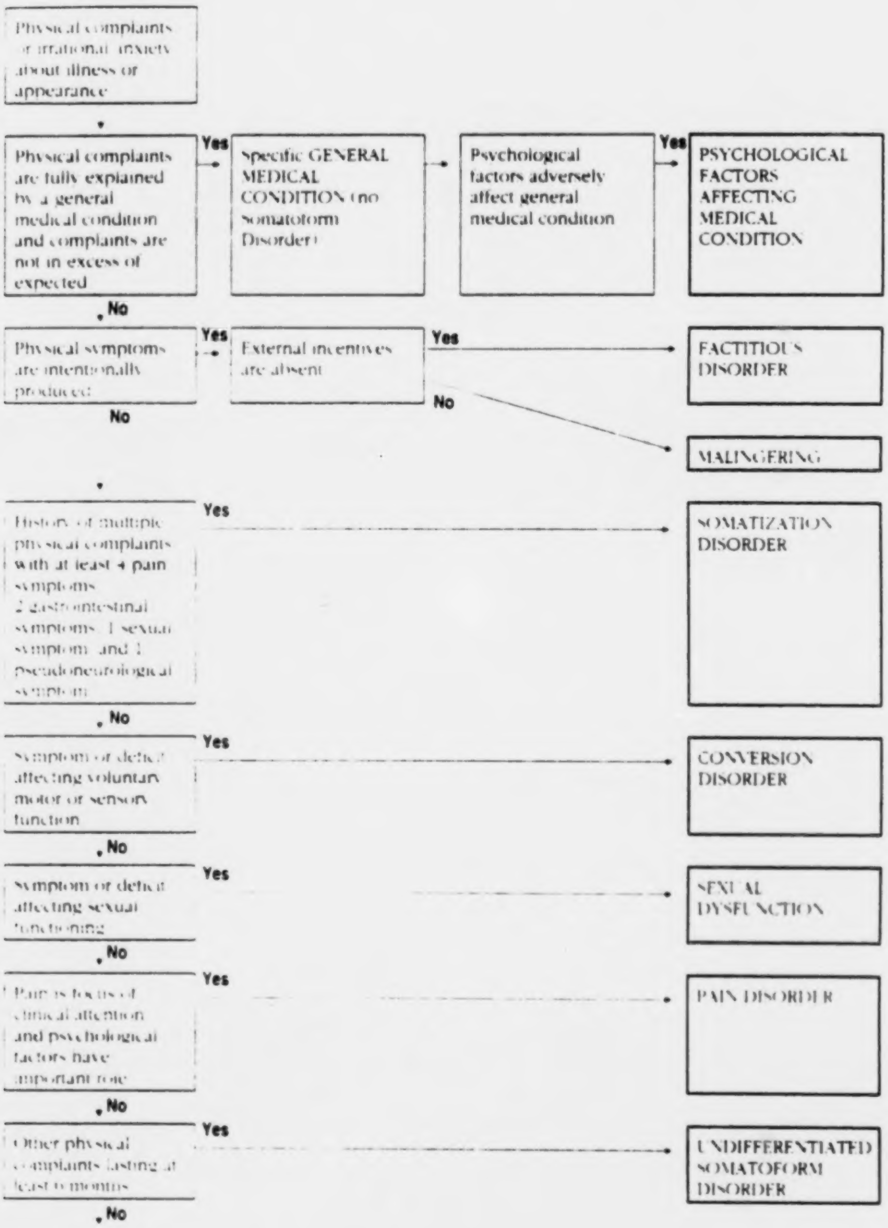
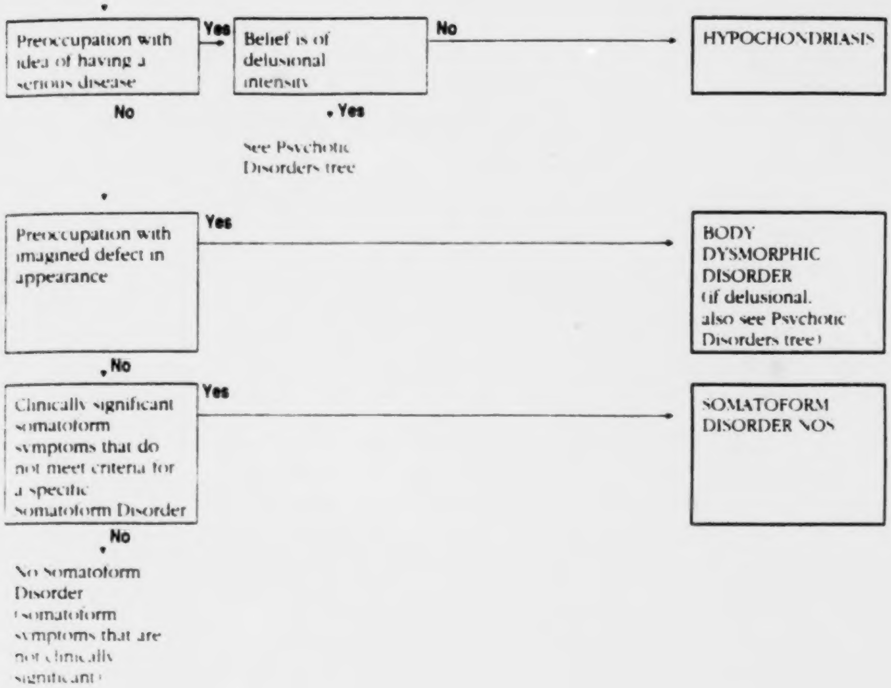

6-month period of excessive anxiety and worry plus associated symptoms
Yes
Occurs exclusively during a Mood or Psychotic Disorder
No
GENERALIZED ANXIETY DISORDER
Yes
See Mood Disorders or Psychotic Disorders tree
No
Anxiety in response to a severe traumatic event
Yes
Reexperiencing of event, increased arousal, and avoidance of stimuli associated with traumatic event
No
No
Yes
Duration of more than 1 month
Yes
POSTTRAUMATIC STRESS DISORDER
No
ACUTE STRESS DISORDER
Anxiety that does not meet criteria for one of the above Anxiety Disorders and develops in response to a stressor
Yes
ADJUSTMENT DISORDER WITH ANXIETY
No
Clinically significant symptoms that do not meet criteria for a specific Anxiety Disorder
Yes
ANXIETY DISORDER NOS
No
No Anxiety Disorder (symptoms of fear, anxiety, or avoidance that are not clinically significant)

Differential Diagnosis of Somatoform Disorders


Physical complaints or irrational anxiety about illness or appearance
Physical complaints are fully explained by a general medical condition and complaints are not in excess of expected
Yes
Specific GENERAL MEDICAL CONDITION (no Somatoform Disorder)
Psychological factors adversely affect general medical condition
Yes
PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION
No
Physical symptoms are intentionally produced
Yes
External incentives are absent
Yes
FACTITIOUS DISORDER
No
MALINGERING
No
History of multiple physical complaints with at least 4 pain symptoms, 2 gastrointestinal symptoms, 1 sexual symptom, and 1 pseudoneurological symptom
Yes
SOMATIZATION DISORDER
No
Symptom or deficit affecting voluntary motor or sensory function
Yes
CONVERSION DISORDER
No
Symptom or deficit affecting sexual functioning
Yes
SEXUAL DYSFUNCTION
No
Pain is focus of clinical attention and psychological factors have important role
Yes
PAIN DISORDER
No
Other physical complaints lasting at least 6 months
Yes
UNDIFFERENTIATED SOMATOFORM DISORDER
No


Preoccupation with idea of having a serious disease
Yes
Belief is of delusional intensity
No
HYPOCHONDRIASIS
No
Yes
See Psychotic Disorders tree
Preoccupation with imagined defect in appearance
Yes
BODY DYSMORPHIC DISORDER (if delusional, also see Psychotic Disorders tree)
No
Clinically significant somatoform symptoms that do not meet criteria for a specific Somatoform Disorder
Yes
SOMATOFORM DISORDER NOS
No
No Somatoform Disorder (somatoform symptoms that are not clinically significant)

ASSESSMENT

FUNCTIONAL ASSESSMENT

Gregory T. Slomka, Ph.D.

Traditional forms of assessment have generally been directed at native ability or capacity, ie., measures of inherent ability. This reflects a psychometric tradition in testing which was established in the 1950s. Measures of general ability such as intelligence and aptitude tests have been increasingly questioned in regard to their ability to predict outcomes with specific clinical populations. Over the years questions have been raised regarding the significance of scores on psychometric tests and their capacity to predict the ability of persons having disabilities to survive in the community.

It was perhaps within the traditions of services for persons diagnosed with mental retardation that this question was most poignantly raised. Traditional assessment with this population relied heavily upon evaluation of formal intelligence with little consideration of other factors. With mandates for least restrictive treatment alternatives and the development of community based treatment services came an awareness of glaring discrepancies in the ability of traditional assessment technologies to aid in treatment and service planning. An anti-psychometric movement, in conjunction with the burgeoning development of "behaviorism," arose within some quarters of the field of the developmental disabilities. Central in this regard was the criticism that traditional testing led only to the generation of generic labels, ie., "Moderate Mental Retardation." Assessment solely for diagnostic or classification purposes was viewed as counterproductive, since it showed little benefit in advancing the predictive potential of individual habilitation efforts.

Within this zeitgeist, we saw the emergence and subsequent development of a radically different assessment technology, that of functional assessment. In only a few years over 125 functional assessment instruments were developed. These instruments purported to increase treatment planning efficacy by refocusing the assessment upon a pragmatic evaluation of individual strengths and weaknesses that a client might show in his or her adaption to specific environmental contexts. At this point, we tended to see dichotomous camps of those who held rigidly to "traditional assessment" and those who ignored this source of data only to focus on outcome measures of adaptive skill competency. In their landmark overview text Mental Deficiency (Clarke and and Clarke (1976)), offered an alternative approach toward evaluation. S.1 Table 1 summarizes their definition of "assessment" which unified aspects from both camps. Central to this model is the recognition of the need to combine assessment technologies so as to develop an appreciation of client need "in toto."

Table 1

An Integration of Traditional and Functional Assessment Approaches

Assessment ...

1) Describes an individual at a particular point in time in terms of intellectual, social, emotional, educational, and allied variables with reference to a normative or contrast population.
2) Predicts performance of an individual at a future point in time.
3) Provides a profile of assets and deficits in order to determine the starting point for further intervention.
4) Provides an objective means to monitor progress over time.

From: Clarke & Clarke, 1976.

The field of psychiatric rehabilitation has also seen an evolution of a functionally based system of assessment. The literature has reflected that in terms of outcome traditional psychodiagnostic assessment methodologies did not correlate with eventual vocational outcome, community adjustment, or with the elucidation of skills requisite for overall community adjustment. A high degree of individual variability can frequently be seen among individuals sharing the same diagnosis. Ratings of personal, social, and work adjustment have, however, correlated highly with eventual client outcome. These ratings also have helped to describe how individual differences affect outcome.

A goal of psychiatric rehabilitation is to assure that an individual with a psychiatric disability can perform those skills necessary to live, work, and learn in his or her community with the least amount of support. Persons with psychiatric disabilities must be able to perform certain functional skills in order to maintain themselves independently in the community or to become re-integrated into the community at large. This is accomplished through two mediums: 1) teaching clients the skills necessary to function as independently as possible, and 2) developing community and environmental resources necessary to support or strengthen functioning if clients fall short of independence. Functional assessment methodologies provide not only a basis for individual prescriptive treatment planning, but also offer a means of addressing various systems-related concerns, such as evaluating intervention effectiveness, monitoring outcomes, and planning for anticipated needs.

The remainder of the discussion will focus upon a further elaboration of functional assessment issues as they pertain to individuals with chronic mental illness. The need to rely not upon any single modality for assessment, but to incorporate functional assessment methodologies into a larger framework of comprehensive evaluation will be emphasized throughout this discussion.

THE DEFINITION AND USES OF FUNCTIONAL ASSESSMENT

Simply defined, functional assessment is the measurement of what a person can and cannot do. That is, the elucidation of behavioral strengths and weaknesses as they relate to particular goals. It is undertaken to aid in determining the impact of physical and mental impairments on behavior. Functional assessment offers a broad range of potentially useful information in the treatment of persons with chronic mental illness. A comprehensive functional assessment allows for S.2 S.3

a) the specification of both abilities and limitations in terms of self-care and instrumental skill functions;

b) the identification of the presence or absence of social and interpersonal skill deficits and strengths;

c) the identification of remediation, training, or compensation techniques; and

d) the identification of educational, vocational, and community support needs.

Strategies utilized in the process of functional assessment vary considerably both in terms of methodology and content. These strategies include both formal and informal techniques. In terms of informal techniques, the presenting background history and psychological test results provide a rich source of antidoctal information which is pertinent to the formation of impressions about functional skill integrity. In particular, psycho-educational, medical, and psychological test reports that provide expanded discussion of pertinent observations about performance, as well as scores, can be quite helpful. Third party reports of functional abilities are an additional resource which may be acquired from family members, professional colleagues, or others S.4

knowledgeable about the client's skills. These types of information can often serve as a springboard for the development of more formalized assessment techniques. Caution is raised, however, regarding the use of information acquired in this fashion because such information lacks objectivity.

THE METHODOLOGIES OF FUNCTIONAL ASSESSMENT

Within the context of "formal" functional assessment, rating scales or questionnaires are often considered in the forefront, as these are the most prevalent and readily available techniques. They represent, however, but one methodology available for use in functional assessment. Table 2 presents four distinct models which can be applied to the functional assessment process. S.5

Table 2

Methods of Functional Assessment

Behavioral Interviewing
Direct Observation
Self-Observation
Checklists, Questionnaires, and Rating Scales

Behavioral Interviewing Techniques. In this methodology, the patient is asked to provide a direct or personal description of assets, deficits, and possible excesses in terms of critical behaviors. Some interviewers utilize a structured interview schedule; that is, all clients assessed would be screened across the same set of questions. Other practitioners are far less structured and utilize behavioral interviewing techniques within the context of a more open-ended, problem-centered interview. There are even recommended assessment methodologies, such as those associated with the Vineland Social Maturity Scale, in which a formal questionnaire (rating scale) provides the basis for an interview. The interviewer does not simply ask a respondent to rate behavior item by item, but rather seeks descriptions of client ability across varied settings, and then utilizes this information to later rate and quantify items on the behavioral questionnaire.

Many clinicians favor the behavioral interviewing methodology for a number of obvious reasons. It "personalizes" the assessment experience and increases the personal role of the client in treatment planning. Critical behavioral issues can be immediately explored in terms of a hierarchy "What"..."When"..."Where"...and "How" so as to obtain knowledge of contingencies and reinforcers that may maintain or preclude specific behaviors. Behavioral interviewing also lends itself to refocusing the client upon phenomenological issues, i.e., what he or she may be doing, thinking, and feeling in specific situations. This process facilitates opportunities for the client to gain insight into those factors which may be contributing to his or her current condition. Finally, in such a process the patient is in an excellent position to aid in hierarchically organizing the "strengths" and "needs" lists. The prioritization of intervention goals becomes a personalized experience for the client. For the clinician, factors which might interfere with such a process become immediately recognized and can become the object of further counseling intervention.

Direct Observation Techniques. One of the most potent means available for functional assessment is the direct observation methodology. Here the client is directly observed "in vivo" or in simulated experiences and his or her behavior is critically evaluated. A good example of this can be seen in the work of the occupational therapist. In order to assess lunch making skills, the client can be taken to an equipped kitchen facility and directly observed across a number of variables which include planning, organization, technique, and outcome. Although direct observation represents both the most valid and reliable means of behavioral assessment, it is also the most costly in terms of manhours.

Typically, we would be more likely to rely on time-sample event recording when using this methodology. Within a particular setting, at specified time intervals, specifically objectified behaviors can be observed in terms of presence, absence, frequency, duration, or intensity. In this fashion, multiple staff members could assume some responsibility for observation and recording of relevant data, thus making the process less labor intensive. Handbooks of behavior therapy are usually repleat with examples of how direct observation and recording techniques can be implemented to evaluate behavior. It is often staff ingenuity that leads to novel approaches toward this type of assessment.

Self-Observation Techniques. A related, but frequently ignored methodology, borrows many of the time- or event-sampling techniques of observational strategies, but uses the client to monitor the identified behavior. At specified time intervals, for example, the client stops, makes a behavioral "check," and enters data. These techniques are particularly valuable for cumulatively monitoring behavior over protracted time periods. Personal attention to appearance and hygiene represent a category of behavior well suited to this technique. In addition, log books, diaries, and event counters (frequency tallies) might be utilized. Central in this methodology is the opportunity for the client actively to self-monitor behavior. In many persons with chronic mental illness, the deficit in the ability to self-monitor represents a primary impediment toward gaining greater social and community acceptance. The greater assimilation on the part of the client of critical self-appraisal of performance rather than reliance on third party evaluations offers an important barometer of autonomy and potential for success in independent living.

Checklists, Questionnaires, Rating Scales. Functional assessment inventories offer a number of distinct advantages in terms of feasibility, breadth of coverage, and economy of application. A number of instruments have been developed and applied across diverse treatment settings. They vary considerably in terms of length and breadth of coverage. In this paradigm, various behaviors are evaluated for presence-absence, quality, frequency, etc. They exist in a number of forms. Ratings may be provided by third parties familiar with the client, such as staff or family. Equivalent forms exist where the client rates his or her own behavior as well. There are instruments which focus exclusively around limited aspects of adaptive functioning, such as vocational skill competencies or self-care skills, while others provide more global ratings across a number of disparate behavioral categories. The attached Appendix provides reference to a diverse sampling of functional rating scales applicable across a number of patient groups. Despite the apparent diversity and availability of standardized rating scales, there remain a number of practical limitations associated with their use. Practitioners frequently report lack of sufficient specificity of the material sampled in comparison to the environmental contexts in which their clients function. An instrument

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might under- or over-sample particular categories of behavior. Those which provide quantitative scores based on normative standardization frequently suffer from restrictive parameters associated with the reference population. A classic example of this is seen in the application of the prototypical functional inventory which is used with persons who are mentally retarded, the Adaptive Behavior Scale. The normative base for this instrument was clients who were institutionally served as opposed to clients who were served in community based programs. Although one of the most frequently cited assessment instruments in use with this population, it remains restricted in its normative application to only institutionally served clients.

Despite these limitations, the rating scale methodology serves a very valuable function in initial case management and service planning by providing a checklist for identification of the presence/absence of critical skills. In terms of aiding in monitoring treatment or service intervention, rating scales and checklists can serve as a base for pre- and post-intervention measures of performance and thus serve as outcome measures. The ideal instrument would offer not only an indication of the "presence or absence" of critical skills, but also the provision of scales which permit objective rating of the frequency of occurrence of targeted skills and the severity of behavioral deficits or maladaptive behaviors. As the development of inventories becomes more refined, we should see improvements particularly in this latter direction.

There remains yet another alternative for the practitioner of functional assessment, that of the development of unique, environmentally or programatically specific instrumentation. A sampling of standardized inventories can be taken in association with an inventory of critical behaviors important in a specific environmental context. Agency or program specific rating scales can then be developed. Such measures can be utilized to develop targets for programatic intervention. It is also quite reasonable to attempt local normatization of such instruments, or to attempt development of criterion validation. An example of this might be that 80% of clients who scored above a specific rating scale score were also successful in transferring to a higher level of programming, it may become reasonable to develop as a treatment plan goal for other clients the attainment of a similar score as an indication of readiness for advancement. Here we see evidence of an instrument not only identifying targets for intervention, but also serving as a criterion measure in a treatment plan.

GENERAL PRINCIPLES OF FUNCTIONAL ASSESSMENT

Regardless of the methodology utilized for obtaining information regarding client assets and liabilities there are certain general principles which can be applied in conducting the assessment and extending this information into generalizations appropriate for treatment or service planning. Cohen and Anthony (1984) provide a number of practical recommendations in this regard. We have taken a number of these principles, which are shown in Table 3, and expanded upon them. Adherence to these principles helps to assure that functional assessment will be both meaningful and practical. S.9

Table 3

The Principles of Functional Assessment

Functional assessment needs to relate to an overall rehabilitation goal that is environmentally specific.

The language of functional assessment must be behaviorally defined.

Functional assessment is always individualized.

Functional assessment must be comprehensive.

Functional assessment requires active client involvement.

Functional assessment should focus on strengths as well as deficits.

Functional assessment requires that the client and the evaluator understand both present and anticipated needs.

From: Cohen & Anthony, 1984.

Functional assessment must relate to an overall rehabilitation goal that is environmentally specific. The objective of assessment is to gain an S.10 understanding of the client's assets and liabilities as they relate to skill demands that are likely to be confronted within particular environments. The needs of the client may vary significantly across the settings in which he or she functions, i.e., the residential, the vocational work place, the S.11 eductional, or recreational. Assessment must, therefore, be "context specific". The evaluator cannot presume that a strength or deficit observed in one environment will necessarily translate across varied boundaries. A central problem we confront in dealing with persons with long term mental illness is the possibility that skills may not generalize across contexts. It is therefore important for the evaluator to consider actively the number of domains in which a particular behavior might have to be assessed. This principle further reinforces the concept of "ecological validity" discussed earlier.

Environmental specificity is also significant because it is this feature which distinguishes functional assessment from more traditional forms of psychometric assessment. Traditional psychological assessment provides a general description of cognitive performance and personality. This description is gathered within the context of a unique social and environmental circumstance--the consulting room. Inferences are drawn and generalized to the broader environment based upon objective results and impressions. Traditional psychological assessment does not, however, provide an opportunity to assess either behavior as a function of the environment in which it occurs or to extend generalizations by specifying how behavior may differentiate across environments. Functional assessment, however, offers a means to assess behavior with "situational specifity." It thereby offers an excellent medium by which to expand upon the results of more traditional assessment methodologies. Utilization of both types of assessment is, therefore, highly recommended.

The language of functional assessment must be behaviorally defined. A "skill" S.12
represents a set of behaviors that are both observable and measurable, and S.13
therefore, "teachable." If we as evaluators are going to translate successfully S.14
observations of client performance into statements which program staff can S.15
act upon, we must convey this information in objective terms. If we are going to attempt to monitor client change, our observations must be in terms which are measurable. The "Rule of the five W's" is an aid in conceptualizing behavior in this fashion. Behaviors must be defined by WHO is performing it, WHAT behavior is the focus of the intervention, as well as by the circumstances associated with the behaviors -- the (WHERE, WHEN, and with

WHOM). These statements are advanced "positively" and in a language of "doing." Expectations for both the client and support personnel are clearly delineated in terms of issues of "personal responsibility."

Functional assessment is always individualized. Each client carries with him or her a unique and distinct phenomonology which sets him or her apart from every other individual. Too often the utilization of a stereotyped approach to behavioral assessment and treatment planning results in the re-application of "pat" formulations of problems and interventions. Too rigid an adherence to a mechanistic formulation of skill deficits that does not take into account "personal" variables can result in glaring failure. Clients are not "black boxes" that respond to stimulus-response heirarchies. S.16

Let us take an example of a not infrequent behavioral problem or symptom, enuresis. The sudden emergence of this problem in a client recently transferred to your program could signal any one of a number of possible underlying etiologies that would influence eventual treatment. So often in "behaviorally oriented" functional assessment there is a tendency to view outcome behavior to the exclusion of potential cause. In this case, the behavior manifested could have its basis in a functional etiology, i.e. anxiety related to transfer. From a psychodynamic perspective enuresis could represent regression to more primitive behavior in the face of weak ego defenses that have been challenged. From a behavioral perspective this same symptom could represent a manifestation of "learned helplessness" that was previously displayed when the client was confronted with uncertainty. A complex alternative set of hypothesis could be derived if we consider medical causes. Could uresis be a function of the sudden onset of diabetes, which is often accompanied by increased urinary frequency? What about the possible neurological causes, such as normal pressure hydrocephalus? Finally, we must also consider yet another factor ever present when serving neuropsychiatric populations. The side effects of medication must be evaluated. This example sets the stage for the next principle of functional assessment.

Functional assessment must be comprehensive. It could be argued that this principle relates not only to the breadth and scope of the assessment methodology, per se, but also to the overall status of the client. That is his or her physical, emotional, social, and cognitive status. The above example highlights the fact that functional assessment does not occur in a vacuum. The active consideration of other assessment data accrued through multidisciplinary means is essential before embarking on treatment.

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This principle has other important implications. Assessment needs to occur across multiple environments. A comprehensive functional assessment also provides for the development of a data base. This data base allows for the construction of short term and intermediate range goals which are built sequentially into more global, long term goals. Such sequential planning is frequently facilitated by organizing the items in a functional assessment inventory into developmental sequences that reflect the normal order of the attainment of more complex behaviors.

Developing a comprehensive functional assessment means it is necessary to go beyond the assessment of pragmatic physical skills, i.e. meal preparation, grooming, handling public transportation. Behaviors must be cast in light of the emotional and intellectual status of the client because problems in these spheres can significantly negatively influence skill acquisition.

Functional assessment requires active client involvement. The extent to which the client is actively involved in the processes of both assessment and treatment planning enhances the probability that he or she will understand "what" will be required and "why". At first glance this may seem obvious. There is, however, a significant issue which relates to persons with long term mental illness and the problem of motivation. Indeed, special effort may have to be given to engaging the client in the assessment and planning process. Active incorporation of the client into treatment planning can aid in "empowerment". The better attuned the client becomes to what is required of him or her and, more importantly, to why it is required, the chances for successful rehabilitation increase. S.22

Functional assessment should focus on strengths as well as deficits. Our ultimate objective is to delineate what the client can as well as cannot do. Often, assessment personnel can slip into a tendency to overfocus on the identification of skill deficits. Functional deficits frequently noted in persons with chronic mental illness include the following: S.23 S.24

- impairment of abstract attitude
- concrete thinking
- inability to make generalizations
- misinterpretation of spoken, written language
- failure to attend
- lack of motivation
- failure to persist in tasks

- lack of eagerness at work
- inability to get along with othe--
- lack of initiative
- psychomotor abnormalities
- disturbance of memory and learning
- slow to process information
- difficulty in categorizing and organizing input

An important aspect of rehabilitation intervention, however, is the identification of areas of residual strength. Frequently it is upon these areas that the therapeutic intervention can be built in order to "remediate" or "compensate for" deficits. It is also important to note that persons with long term mental illness often readily develop a negative self-focus. Anticipation of failure can be a significant stumbling block. The identification of residual strengths can become an important source of therapeutic benefit for certain clients. The development of an improved self-image through this process then influences more positive motivation toward program goals.

Functional assessment requires that the client and the evaluator understand both present and anticipated needs. Rehabilitation effort is understood as a "process" that is ongoing. So, too, must evaluation be understood. The practitioner must assume the perspective, "Where is my client currently; where does he or she need to be in the immediate and long term future?" As indicated previously, it is critical that efforts be directed toward a superordinate goal. Assessment and intervention provide the bridges to span the gaps between the client's current status and intended outcomes. The process runs smoothly to the degree that both the client and practitioner 5.25

agree upon realistic goals and methods. Comprehensive functional assessment provides a valid basis for the decision making regarding intermediate goals which build logically toward more extended goals.

By considering the principles outlined above we can further refine our definition of functional assessment. According to Lawton (1971) functional assessment refers to "any systematic attempts to measure objectively the level at which a person is functioning in any of a variety of areas such as physical health, quality of self-maintenance, quality of role activity, intellectual status, social activity, attitude toward the world and toward self, and emotional status (p.). Conceived in this fashion, functional assessment as a methodology offers an approach to the central question confronted by service providers: How may I help my clients/patients who have chronic impairment to achieve maximum quality of life and independence in daily activities?"

At its simplest, functional assessment represents a means to describe S.26
abilities. Our goal as service and treatment providers is to develop a S.27
performance oriented data base or profile of our clients. From this profile S.28
problems and needs are mutually identified, interventions are planned, and long
term goals are developed. Periodic re-evaluation across these performance
measures provides the means to quantitatively ascertain progress toward the
attainment of long term goals. In effect, functional assessment data provides S.29
a foundation of data relevant for many types of both case management as well
as treatment related services.

If one adopts the recommendations described above for conducting any S.30
type of functional assessment, that is, behaviorally defining skills and needs S.31
in terms that are observable and measurable and following the "rule of the S.32

five W's", one has the groundwork available for the ready translation of raw data into prescriptive treatment plans.

We emphasize that functional assessment remains only one spoke in a more intricate wheel. Each client presents unique physical and biological endowments, cognitive strengths and weaknesses, affective characteristics, and interpersonal skills. The failure to assess instrumental community based adult daily living (ADL) skills or vocational skills against the backdrop of the aforementioned variables can lead to complications. We have attempted to convey the need to develop service planning only after comprehensive evaluations are complete. The most successful rehabilitation strategies are those which are built upon the client's existing skills, talents, and resources.

SPECIAL FUNCTIONAL IMPAIRMENTS IN POPULATIONS WITH CHRONIC MENTAL ILLNESS

The development of knowledge about how psychopathology is uniquely manifested across various syndromes is one function of the DSM-III-R classification system. We must, however, look beyond mere description and S.33
further examine how various symptom constellations impact daily functioning. S.34
The symptoms themselves can represent significant impediments to adaptive functioning. We will begin with a consideration of the psychoses and consider potential repercussions of such symptoms on performance. Delusions, hallucinations, and fantasies interfere with performance by blocking or diverting attention from reality demands. Autistic preoccupation significantly interferes with the ability to attend to or respond to interpersonal cues from the world at large. These symptoms are the most obvious, florid, and immediately disabling. They are, however, the symptoms which respond most

immediately to neuroleptic medications.

There are a number of more residual secondary symptoms which can be manifested even in the face of controlled Schneiderian First Rank Symptoms. Social isolation can reflect itself in anxiety or in severe interpersonal discomfort in social situations. Diminished attention to grooming and hygiene or the improper modulation of behavior in public may negatively influence social acceptance. Oddities in speech and mannerisms might further exacerbate this. Suspiciousness associated with paranoid ideation can radically affect factors such as response to constructive criticism. Subtle thought disorganization and impaired judgement and reasoning can negatively influence complex problem solving. The person who deals with the environment successfully possesses the ability to interpret social cues and react within the boundaries of normal social convention. It can be readily seen, therefore, that psychotic symptoms alone or in combination can seriously interfere with adaptive functioning.

We can also associate functional limitations with the symptoms accompanying the affective disorders. Depression, for example, conveys impressions of dysphoric mood and diminished performance ability. Clients vary significantly in the degree to which neurovegetative (sleep, appetite, and arousal state) symptoms are manifested. Fatigue and decreased energy can radically affect performance level on the job or in educational arenas. These symptoms may dissipate or they may remain chronically refractory in some patients, thus having long term repercussions. We are now also increasingly recognizing the "cognitive" as well as the affective repercussions of depressive disorders. Severe impairment in occupational efficiency, memory and concentration, and practical problem solving can occur and can be more functionally debilitating in the workplace than the mood disturbance.

We have only briefly highlighted the "functional" ramifications of symptoms in order to emphasize the need to assess their impact upon a client's "everyday functioning." It is indeed relevant to take the individual symptomolgy associated with any DSM-III-R major psychiatric disorder and attempt to conceive its impact upon the client in the domains as seen in Table 4. The breakdown of symptom related problems into such subsets is one means of further understanding their specific impact and then individualizing potential intervention or compensatory strategies.

Table 4 S.35

Sub-sets of Symptom-Related Problems

Sensory-perceptual disturbance
Cognitive disturbance
Language related disturbances
Praxic (motor) disturbance
Disrupted executive functions

There is further advantage to maintaining a symptom-related focus while conducting functional assessment. Once symptoms and problems are clearly defined with this population, it is important to identify the factors which maintain them. Here we are emphasizing the need to understand the etiological underpinnings of problematic behavior from a biopsychosocial perspective. Treatment efforts should follow as a function of the identification of casual determinants. Psychological factors related to genetic, metabolic, and physical abnormalities may require primarily pharmacological models of intervention. To the degree that psychosocial factors may influence the course of a disorder (onset, exacerbation, relapse and chronicity,) behavioral and social interventions will be more appropriate. In this case the clinician would focus more specifically on the antecedent and consequent events that maintain problematic behavior. Frequently, it is a combination of both treatment strategies that is required.

BEHAVIORAL ASSESSMENT STRATEGIES

We will focus next on how environmental factors can be more specifically examined to assess their influence on behavior. The practitioner engages in intensive analysis of the factors that support and maintain problematic behavior. Many resources are available which describe the principles of applied behavioral analysis. This discussion will touch briefly on only four important components of the process: the understanding of the SETTING in which the behavior takes place, the FREQUENCY or DURATION, and the ANTECEDENT as well as the CONSEQUENT influences. S.36

Setting. The first functional assessment principle discussed by Cohen and Anthony (1984) focused on the need for environmental specificity. The first critical question to be answered is, "In what situations does problematic behavior occur?". In the home? ... At work? ... In public places? ... In isolation? One attempts to establish how generalized or situationally specific the problematic behavior may be. This indicates how complex and focused the resources associated with intervention must be. For example, will the strategies utilized in the Job Club be the same as those applied in the residential program?

Frequency. It is next important to ascertain the frequency or intensity of the problematic behaviors. Not only must we be interested in how frequently problematic behavior occurs, but also in the relative severity. A low frequency severe behavior problem such as self-abuse occurring once or twice a week would be considered more critical for intervention than a high frequency obsessive-compulsive behavior problem that is quite innocuous, such as hand wringing.

Antecedent Influences. One next focuses on antecedent conditions. What led up to the behavior in question? Antecedent events are rich and complex in their presentations and cover a number of spheres beyond the "behavioral" one that is most commonly conceived. A few examples are seen in Table 5. S.37

Table 5

Antecedent Events that may lead to Problematic Behavior

EVENT CATEGORY	EXAMPLE
Cognitive	Impulsive cognitive set, failure to appreciate full ramifications of action
Affective	Feeling dysphoric on a particular day
Interpersonal	Low self-esteem with overreaction to ridicule
Situational	Repeat of same circumstances encountered last week
Imaginary	Fantasy of worst case scenario - "I'm sure I'll fail."
Biological	Lack of sleep the night before, and forgot morning medications

Any one or a combination of these factors could trigger problematic behavior. The practitioner's job is to delineate isolated (infrequent) antecedent events from those which are encountered more frequently and tend, therefore, to sustain the problematic behavior.

Consequence. The consequence of a behavior affects its frequency, duration and intensity. Consequences serve to strengthen, weaken, or extinguish a problematic behavior. The "art" in applied behavioral intervention centers on the ability to grasp the nuances of the reinforcement hierarchies that shape behavior. Simply defined, reinforcers are environmental consequences which increase the probability a preceding behavior will occur or be learned in the future. In populations of persons with chronic psychiatric disability, an important function in rehabilitation is one of propogating a set of new, socially appropriate reinforcers to help sustain desired behaviors.

BEHAVIORAL EXCESSES, DEFICITS, AND ASSETS

S.38

One can well imagine at this point that a comprehensive assessment of a person with a long term chronical mental illness could result in the identification of multiple problematic behaviors. The practitioner is faced with numerable issues which have the potential to positively or negatively impact behavior in a particular program. One means of dealing with this potential "information overload" is to reframe behaviors in the context of excesses, deficits, and assets. In this fashion, the most problematic negative behaviors are identified (the deficits and excesses), while at the same time the focus of the client is also directed toward his or her assets. These assets represent "building blocks." By "keying" on assets, adaptive behavior can be strengthened and problematic behavior displaced.

Behavioral excesses represent maladaptive behaviors that occur at rates or intensities so high that they interfere with normal adaptive functioning. Handwashing, a routine activity, becomes pathogonomic in the patient with obsessive-compulsive disorder when it occurs 50 times a day. Behavioral deficits represent necessary behaviors that occur with insufficient frequency, inadequate intensity, or in an inappropriate form. The "negative symptoms" of clients having schizophrenia are representational of this class of deficits. Behavioral assets include the social competencies, coping efforts, skills, interests, and abilities of the client, as well as his or her available social supports.

Moving beyond the simple identification of "strengths and needs" one needs to translate outcome goals to specific behavioral categories that will become the object of treatment intervention. This is readily seen in the following example. A middle aged male with a chronic history of refractory schizophrenic symptomology is discharged from a state hospital to your care. He presents with very good social-conversational skills. His delusions, however, remain quite chronic. He becomes self-absorbed with their content, particularly when he is alone or idle. He spends greater than 70% of every idle hour engaged in "self-talk." Lower rates of reported delusional references are reported when he is engaged in social activities. When information is reported and structured in this fashion, it becomes readily apparent what strategies you might immediately consider regarding intervention.

We will address one further point in this regard-- the need to train ourselves to refocus our assessments on identification of assets. It becomes increasingly easy to slip into a cognitive set in which we focus primarily on analysis of client deficits. We are repeatedly reminded to focus on assets from a number of quarters. You have noted that even in DSM-III-R diagnostic formulations there is an emphasis on assets or a documentation of "the highest level of adaptive functioning". In conducting functional assessments one should attempt to develop an "Inventory of Assets." We emphasize the need to go beyond the simple listing of strengths as might be ascertained from an adaptive behavior rating scale. The inventory should include an analysis of the supplemental information that can be derived from interview, collection of records, and review of history, all of which make this information more situationally relevent. The following questions can be used to organize this information:

1. What are the areas in which the client has consistently functioned best now and in the immediate past?
2. What does my client view as his or her most significant asset?
3. What is the extent of his or her available resources in terms of interpersonal and social supports?
4. What agencies and helping professionals are available to be mobilized in his or her behalf? With whom are there established favorable relationships?
5. What personal motivations and incentive to change have been identified?
6. What are the positive aspects of my therapeutic alliance with this client?

When we move beyond the simple listing of "assets" to considering their implications in terms of "systems related issues" that are pertinent to the client's support, we have laid a foundation for the transfer of this information into viable recommendations for service or treatment.

THE NESTED SKILLS APPROACH TO ASSESSMENT AND TRAINING

We will offer one final strategy to be incorporated in the methodologies of functional assessment recommended as appropriate for use with this population. Critical in the rehabilitation of the individual with long term chronic disability is the question of whether or not the client can be trained and carry out routines of behavior. Our lives do not consist of carrying out discrete, isolated behaviors. Rather, our behavior reflects intricate routines and sub-routines organized in a complex interdependent fashion. Groups of actions are organized to meet the environmental demands with which we are confronted. S.39

Up to now we have only spoken of functional assessment and intervention strategies occurring in a unitary or discrete fashion. Are they present or absent? How frequently do they occur? A more critical question centers on the ability of the client to carry out complex multi-step operations and integrated actions. How effective is he or she in adapting behavior in the face of conflicting or changing environmental demands. How complex a routine is he or she capable of carrying out?

Let's consider an example taken from the assessment of self-care skills associated with early morning routines. Typically we would assess component skills associated with the discrete activities involved, i.e., toileting, washing, shaving, toothbrushing, grooming, dressing. When we think of our own behavior, we quickly realize how we rely upon "routines" in conducting such activities. It is frequently the case that we could assess our client and find him or her fully competent when asked to perform appropriately each isolated activity. Missing in this limited analysis, however, is the evaluation of the degree to which the client can self-initiate and self-monitor these activities. Specifically, is he or she self-motivated to perform this sequence of activities daily? Are there breakdowns in the sequence such that day to day they are completed in "hit or miss" fashion? Are some behaviors initiated appropriately, but haphazardly carried out? Clients facing the consequences of long term chronic mental illness typically have not lost the basic skills in conducting such activities, but have developed deficiencies in the "executive functions" which relate to planning, organizing, or maintaining such activities. Although this is perhaps an overly simplistic example, one can extend the analogy to some of the complex behavioral expectancies we impose on our clients. We must be mindful of breaking our assessment and training strategies into formats that permit a determination of how well the client can proceed through multi-step and sequential operations. Critical in this regard is the question, "Can the client consistently maintain these sequences?". We will frequently find that we do not have to engage in skill acquisition training, as much as we have to refocus on developing strategies that will aid the client in the more effective use of the self-monitoring, judgement, and reasoning skills needed to maintain daily routines.

RESOURCE MANAGEMENT

Once the functional assessment has been conducted and goals identified, resources must be inventoried and organized before proceeding with the rehabilitation plan. The client and counselor must actively consider the required resources which will have to be brought to bear in program implementation. This relates to multiple factors such as time, money, agencies, facilities, or transportation. There will need to be a delineation of who will assume the responsibility to carry out individual aspects of the plan. A comprehensive assessment of the client's capacity to carry out complex behaviors as highlighted above should aid greatly in determining the degree to which support will have to be extended in various areas. This support, in turn, will facilitate the client's maximum participation in the rehabilitation process.

SUMMARY

An overview of principles associated with functional assessment has been provided. An attempt was made to highlight a variety of methodologies available toward this end. Within this context, special considerations were advanced which related to the assessment needs of clients having chronic psychiatric disability. We return to the comments made at the beginning of this presentation. Functional assessment was conceived as an important tool to supplant limitations associated with more traditional testing for treatment planning. We would hope that the practitioner utilizing the functional assessment technologies described above not only incorporates them wisely, but also extends the general philosophy of assessment which has been advanced. In a truly **comprehensive** approach toward assessment, adoption of a functional approach toward testing provides a definition of the client's: 1) information processing style, 2) cognitive strengths and deficits, 3) problem solving skills, 4) coping resources, 5) personality style, as well as 6) strengths and weaknesses in environmentally specific skills that pertain to his or her residence, work, and social milieus. S.40

Functional assessment represents not a mechanistic approach to problem identification via the pat administration of behavior rating scales, but rather it represents a philosophy which can be adapted toward more traditional forms of medical, psychological, and social casework assessment strategies as well. Indeed, this philosophy can be adapted to any evaluation which attempts to contribute to the understanding of how the quality of life and independence of a client with chronic mental illness can be furthered.

We will now conduct an exercise which helps illustrate a number of the points we made in this presentation.

PSYCHOSOCIAL SUMMARY

Client Name ____________________ Evaluator ______________________________

ID Number ______________________ Agency ________________________________

Date _________________________

Basic Environmental Supports

Does the client have an effective support system?

Family ____ Y ____ N

Peer ____ Y ____ N

Institutional ____ Y ____ N

Does the client maintain a stable residence? ____ Y ____ N

Is the client active with a MH provider? ____ Y ____ N

Specify corrective action if necessary:

____

____

____

Physical Health

Are there significant physical health problems? ____ Y ____ N

Describe (i.e., well-controlled, may complicate programming):

____

____

____

If indicated, is follow-up provided? ____ Y ____ N

Describe (i.e., where, by whom, how often):

____

____

____

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Psychiatric Status

Check for the presence of any major symptom cluster

If Present:	Acute	Chronic/Residual	In Remission
____ Psychotic Experiences	____	____	____
____ Depression	____	____	____
____ Manic Symptoms	____	____	____
____ Anxiety or Fears	____	____	____
____ Obsessions or Compulsions	____	____	____
____ Organic Dysfunction	____	____	____
____ Drug Abuse	____	____	____
____ ETOH Abuse	____	____	____
____ Suicide Attempts	____	____	____
____ Other Symptoms	____	____	____

Specify action necessary around any current symptoms manifestation:

____

____

____

____

Has the client demonstrated consistent medication compliance? ____ Y ____ N

For how long? ____________________

Intrapersonal Factors:

Can client readily discuss impact of his symptoms on behavior and lifestyle? ____ Y ____ N

If no, does he/she tend to:
____ Deny
____ Avoid
____ Use Sick Role

Client's personal rehabilitation aims/personal incentives toward change:

Noteworthy disincentives toward maintenance of employment:

CRITICAL SKILLS CHECKLIST

Client name ______________________ Evaluator ______________________

ID Number ______________________ Agency ______________________

Date ______________

INSTRUCTIONS: Circle the appropriate category indicating how well each of the following critical skills are performed according to the definition key below:

Very Poor (1) - skill performance is very poor or absent

Poor (2) - skill performance is poor or inconsistent at best

Adequate (3) - skill performance is adequate (meets current needs)

Good (4) - skill performance is good (effective, consistent/efficient)

Superior (5) - skill performance is highly satisfactory (particular strength)

No (N) - cannot be determined; skill performance in need of further evaluation

The Environmentally Specific Comments section is used to specify environmental and behavioral parameters in summarizing skill performance, i.e., quantity: frequency, duration, consistency, reliability; quality: thoroughness, accuracy, desirability, expediency, efficacy; and level of independence: level/frequency of supervision, prompting. Comments here should further elucidate client strengths which may be capitalized upon, as well as deficit areas which may be targeted for intervention.

Specify the environment for which this assessment was completed: ______________________

____

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A. LANGUAGE/COMMUNICATION

- engages in every day conversation	1	2	3	4	5	N
- understands verbal commands, directions	1	2	3	4	5	N
- responds to nonverbal contextual cues	1	2	3	4	5	N
- expresses needs & feelings	1	2	3	4	5	N

Environmentally Specific Comments:

B. MEMORY AND LEARNING

- recalls basic environmental information (names, address,telephone and Social Security number, simple directions)	1	2	3	4	5	N
- remembers appointment times and schedule of activities	1	2	3	4	5	N
- recalls long-term information (work or educational history)	1	2	3	4	5	N
- comprehends written materials	1	2	3	4	5	N
- learns from hands-on experience	1	2	3	4	5	N
- learns from verbal instructions	1	2	3	4	5	N

nvironmentally Specific Comments:

C. ATTENTION/CONCENTRATION

- sustains attention to aurally presented information	1	2	3	4	5	N
- sustains attention to task task at hand	1	2	3	4	5	N

Environmentally Specific Comments:

D. PROBLEM SOLVING AND CONCEPTUALIZATION

- makes reasonable decisions	1	2	3	4	5	N
- formulates a plan	1	2	3	4	5	N
- carries out a plan	1	2	3	4	5	N
- generalizes a concept across settings	1	2	3	4	5	N
- responds to constructive criticism	1	2	3	4	5	N

Environmentally Specific Comments:

E. DAILY LIVING

- attends to personal hygiene (shower, shampoo, deodorant)	1	2	3	4	5	N
- uses a telephone	1	2	3	4	5	N
- engages in leisure time activities	1	2	3	4	5	N
- reads a newspaper	1	2	3	4	5	N
- budgets money	1	2	3	4	5	N
- plans a nutritionally balanced meal	1	2	3	4	5	N
- prepares meals adequately	1	2	3	4	5	N
- shops for personal items	1	2	3	4	5	N
- uses public transportation	1	2	3	4	5	N
- accesses necessary resources (Social Security, Medical care, etc.)	1	2	3	4	5	N

Environmentally Specific Comments:

F. SELF APPRAISAL AND JUDGMENT

- evaluates severity of external stressors	1	2	3	4	5	N
- copes with mild stress	1	2	3	4	5	N
- seeks support if unduly stressed	1	2	3	4	5	N
- verbalizes relevant and appropriate personal goals	1	2	3	4	5	N

Environmentally Specific Comments:

G. STAMINA AND TOLERANCE

- tolerates a 6-8 hour workday	1	2	3	4	5	N
- lifts objects 35-50 lbs	1	2	3	4	5	N
- traverses 100 yards without fatigue	1	2	3	4	5	N

Environmentally Specific Comments:

KEY:
1 = Very Poor
2 = Poor
3 = Adequate
4 = Good
5 = Superior
N = In need of further evaluation

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APPENDIX

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FUNCTIONAL ASSESSMENT

Gregory T. Slomka, Ph.D.

Slide 1.

ASSESSMENT (Clarke & Clarke, 1976)

1) Describes an individual at a particular point in time in terms of intellectual, social, emotional, educational, and allied variables with reference to a normative or contrast population.
2) Predicts performance of an individual at a future point in time.
3) Provides a profile of assets and deficits in order to determine the starting point for further intervention.
4) Provides an objective means to monitor progress over time.

Slide 2.

FUNCTIONAL ASSESSMENT

A MEASURE OF WHAT A PERSON CAN OR CANNOT DO (STRENGTHS/WEAKNESSES) IN PARTICULAR SITUATIONS AND IN LIGHT OF PARTICULAR GOALS AND OBJECTIVES

Slide 3.

RATIONALE FOR FUNCTIONAL ASSESSMENT OF CMI INDIVIDUALS

1) PROVIDES INFORMATION ON SPECIFIC ABILITIES AND FUNCTIONAL LIMITATIONS.
2) IDENTIFIES THE PRESENCE OF SOCIAL/INTERPERSONAL DEFICITS.
3) IDENTIFIES LEARNING STYLES AND EFFECTIVE COMMUNICATION TECHNIQUES.
4) IDENTIFIES REMEDIATION AND COMPENSATION CONSIDERATIONS.
5) PROVIDES INFORMATION REQUIRED FOR PLANNING AND ACCOMMODATION TO CHANGE.
6) IDENTIFIES EDUCATIONAL AND TRAINING NEEDS.
7) IDENTIFIES JOB PLACEMENT NEEDS.
8) IDENTIFIES COMMUNITY SUPPORT NEEDS.

Slide 4.

SOURCES OF FUNCTIONAL ASSESSMENT DATA

- DIAGNOSTIC INFORMATION
- TEST RESULTS
- QUESTIONNAIRES AND SURVEYS
- DIRECT OBSERVATIONAL TECHNIQUES
- CLIENT SELF MONITORING
- CLIENT INTERVIEW
- SIGNIFICANT OTHERS
- HISTORICAL INFORMATION
- PRACTITIONER COLLABORATION

Slide 5.

METHODS OF FUNCTIONAL ASSESSMENT:

- BEHAVIORAL INTERVIEWING
- DIRECT OBSERVATION
- SELF-OBSERVATION
- CHECKLISTS, QUESTIONNAIRES, AND RATING SCALES

Slide 6.

FUNCTIONAL ASSESSMENT INSTRUMENTS

FUNCTIONAL ASSESSMENT INVENTORY (FAI)

PERSONAL CAPACITIES QUESTIONNAIRE (PCQ)

PATIENT'S ASSESSMENT OF OWN FUNCTIONING INVENTORY (PAOFI)

REHABILITATION INDICATORS (RIs)

Slide 7.

SCALES IN THE FUNCTIONAL ASSESSMENT INVENTORY (FAI) GROUPED ACCORDING TO APPARENT CONTENT

Motor
- Upper extremity functioning
- Hand functioning
- Coordination
- Ambulation or mobility
- Motor speed
- Capacity for exertion
- Endurance
- Speech

Social and biographical
- Effective interaction with people
- Personal attractiveness
- Skills
- Work history
- Absence from work due to treatment or medical problems
- Stability of condition
- Social support system

Psychological and intellectual
- Learning ability
- Judgment
- Memory
- Literacy
- Language functioning
- Perceptual organization
- Persistence
- Work habits
- Consistency of behavior with rehabilitation goals
- Accurate perception of disability

Sensory
- Vision
- Hearing

Environmental
- Access to job opportunities
- Economic disincentives
- Acceptability to employers

Slide 8.

SAMPLE RATING SCALES OF THE FAI

Functional Limitations Scale No. 10: Endurance
- 0 -- No significant impairment
- 1 -- Can work full day with rest periods arranged
- 2 -- Can work only about half-time
- 3 -- Unable to work for more than 1 or 2 hours a day

Functional Limitations Scale No. 13: Judgment
- 0 -- No significant impairment
- 1 -- Sometimes makes unsound decisions: doesn't take time to consider alternative or consequences of behavior
- 2 -- Frequently makes rash or unwise decisions; often displays inappropriate behavior or choices
- 3 -- Could be dangerous to self or others as a result of foolish or impulsive behavior

Functional Limitations Scale No. 27: Work History

0 -- No significant impairment
1 -- Has little or no work experience due to youth or other reasons acceptable to most employers
2 -- Work history includes such negative aspects as frequent tardiness or frequent job changes with periods of unemployment
3 -- May have periods of unemployment as great as 5 years; references when available are poor

Strength Items

- Has an unusually attractive physical appearance
- Is extremely bright, or has an exceptional verbal fluency
- Is extremely motivated to succeed vocationally

Slide 9.

FUNCTIONAL ASSESSMENT PRINCIPLES
(COHEN & ANTHONY, 1984)

FUNCTIONAL ASSESSMENT NEEDS TO RELATE TO AN OVERALL REHABILITATION GOAL THAT IS ENVIRONMENTALLY SPECIFIC.

THE LANGUAGE OF FUNCTIONAL ASSESSMENT MUST BE BEHAVIORALLY DEFINED.

FUNCTIONAL ASSESSMENT IS ALWAYS INDIVIDUALIZED.

FUNCTIONAL ASSESSMENT MUST BE COMPREHENSIVE.

FUNCTIONAL ASSESSMENT REQUIRES ACTIVE CLIENT INVOLVEMENT.

FUNCTIONAL ASSESSMENT SHOULD FOCUS ON STRENGTHS AS WELL AS DEFICITS.

FUNCTIONAL ASSESSMENT REQUIRES THAT THE CLIENT AND THE EVALUATOR UNDERSTAND BOTH PRESENT AND ANTICIPATED NEEDS.

Slide 10.

FUNCTIONAL ASSESSMENT MUST RELATE TO AN OVERALL

REHABILITATION GOAL THAT IS ENVIRONMENTALLY SPECIFIC.

Slide 11.

AREAS IN WHICH ADAPTIVE FUNCTIONING MIGHT BE ASSESSED

SELF-CARE

HOUSEKEEPING

LEISURE

PERSONAL BUSINESS AND FINANCE

CONSUMER ACTIVITIES

SCHOOL

WORK

SPECIAL EVENTS

Slide 12.

FUNCTIONAL ASSESSMENT REQUIRES THAT SKILLS AND DEFICITS BE BEHAVIORALLY DEFINED.

Slide 13.

WORKER ROLE KNOWLEDGE AND SKILLS

- APPROPRIATE VOCATIONAL GOAL
- ADEQUATE KNOWLEDGE OF VOCATIONAL OPTIONS
- APPLICATION SKILLS
- INTERVIEW SKILLS
- CLIENT/CO-WORKER INTERACTIONAL SKILLS
- CLIENT/SUPERVISOR INTERACTIONAL SKILLS
- ADEQUATE KNOWLEDGE OF WORKER ROLE REQUIREMENTS

Slide 14.

FUNCTIONAL COMMUNITY SKILLS

- TRANSPORTATION SKILLS
- FUNCTIONAL ACADEMIC SKILLS
- SELF-CARE SKILLS (HYGIENE, NUTRITION)
- USE OF MONEY
- MANAGEMENT OF PERSONAL AFFAIRS
- MEDICAL CARE

Slide 15.

SOCIAL AND COMMUNICATION SKILLS

- FACE TO FACE COMMUNICATION
- SOCIAL INVOLVEMENT
- LEISURE AND RECREATION
- TELEPHONE SKILLS
- ABILITY TO MEET PEOPLE
- ABILITY TO "GET ALONG" WITH OTHERS

Slide 16.

EFFECTIVE FUNCTIONAL ASSESSMENT IS ALWAYS INDIVIDUALIZED.

Slide 17.

FUNCTIONAL ASSESSMENT MUST BE COMPREHENSIVE.

Slide 18.

VOCATIONAL FUNCTIONING AND POTENTIAL

THE DEGREE TO WHICH A CLIENT DEMONSTRATES CAPACITY TO APPRAISE REALISTICALLY HIS/HER OWN VOCATIONAL POTENTIAL AND TO EXHIBIT PHYSICAL AND EMOTIONAL ENDURANCE NECESSARY TO ACHIEVE VOCATIONAL OBJECTIVES

Slide 19.

ECONOMIC INDEPENDENCE

THE DEGREE TO WHICH THE CLIENT CAN FUNCTION INDEPENDENTLY IN SOCIETY WITHOUT RELIANCE ON PUBLIC SUPPORT FOR INCOME AND SOCIAL SERVICE

Slide 20.

PHYSICAL FUNCTIONING

THE DEGREE TO WHICH THE CLIENT DEMONSTRATES THE CAPACITY FOR REDUCTION OF SYMPTOMS, IMPROVED PHYSICAL TOLERANCE, DEVELOPMENT OF PRACTICAL COMPENSATORY MECHANISMS, AND INCREASED ENDURANCE

Slide 21.

PSYCHOSOCIAL FUNCTIONING

THE DEGREE TO WHICH A CLIENT DEMONSTRATES SOCIAL AND PSYCHOLOGICAL ADAPTABILITY WHICH SERVE TO ENHANCE FEELINGS OF SECURITY, ADEQUACY, FUNCTIONAL CAPABILITY, EMOTIONAL STABILITY, AND SOCIAL INTERACTION

Slide 22.

FUNCTIONAL ASSESSMENT REQUIRES ACTIVE CLIENT INVOLVEMENT.

Slide 23.

FUNCTIONAL ASSESSMENT SHOULD INCLUDE A MEANS FOR MEASUREMENT OF BEHAVIORAL SKILLS STRENGTHS AS WELL AS DEFICITS.

Slide 24.

FUNCTIONAL DEFICITS FREQUENTLY NOTED IN THE CMI

- IMPAIRMENT OF ABSTRACT ATTITUDE
- CONCRETE THINKING
- INABILITY TO MAKE GENERALIZATIONS
- MISINTERPRETATION OF SPOKEN, WRITTEN LANGUAGE
- FAILURE TO ATTEND
- LACK OF MOTIVATION
- FAILURE TO PERSIST IN TASKS
- LACK OF EAGERNESS AT WORK
- INABILITY TO GET ALONG WITH OTHERS
- LACK OF INITIATIVE
- PSYCHOMOTOR ABNORMALITIES
- DISTURBANCE OF MEMORY AND LEARNING
- SLOW TO PROCESS INFORMATION
- DIFFICULTY IN CATEGORIZING AND ORGANIZING INPUT

Slide 25.

FUNCTIONAL ASSESSMENT REQUIRES AN UNDERSTANDING OF BOTH PRESENT AND NEEDED LEVEL OF FUNCTIONING OF THE CLIENT.

Slide 26.

FUNCTIONAL ASSESSMENT IS A MEANS TO DESCRIBE ABILITIES.

Slide 27.

THE GOAL OF FUNCTIONAL ASSESSMENT

TO DEVELOP A PERFORMANCE-ORIENTED DATABASE OR PROFILE

Slide 28.

FROM THIS PROFILE:

PROBLEMS OR NEEDS ARE IDENTIFIED

INTERVENTIONS ARE PLANNED

LONG RANGE GOALS ARE DEVELOPED

Slide 29.

FUNCTIONAL ASSESSMENT PROVIDES CORE INFORMATION FOR "CASE MANAGEMENT".

Slide 30.

FUNCTIONAL ASSESSMENTS REQUIRE SKILLS BE BEHAVIORALLY DEFINED.

Slide 31.

A SKILL IS A SET OF BEHAVIORS THAT IS:

OBSERVABLE

TEACHABLE

MEASUREABLE

Slide 32.

RULE OF THE FIVE "Ws"

WHO IS PERFORMING

WHAT BEHAVIORS ARE THE FOCUS

AND THE CIRCUMSTANCES (WHERE, WHEN, WITH WHOM)

Slide 33.

FACTORS OF PERSONS HAVING CMI WHICH INFLUENCE VOCATIONAL OUTCOME

1. ADJUSTMENT TO DISABILITY
2. COGNITIVE/INTELLECTUAL ABILITIES
3. DECISION MAKING ABILITIES
4. DEPENDENCY ON OTHERS FOR FINANCIAL SUPPORT
5. DISINCENTIVES (E.G., SEVERELY LIMITING MEDICAL CONDITIONS)
6. PREMORBID EDUCATIONAL LEVEL
7. EMOTIONAL STATUS
8. INDEPENDENCE IN LIVING, MOBILITY, AND JOB PERFORMANCE

Slide 34.

9. MARITAL STATUS AND NUMBER OF DEPENDENTS
10. MOTIVATION AND EGO STRENGTH
11. PERCENT OF TIME ABLE TO WORK
12. PHYSICAL STATUS
13. PRODUCTIVITY (INCLUDING CREATIVE AND COMMUNITY ACTIVITIES)
14. SOCIAL FUCNTIONING
15. DEGREE OF TRAINING REQUIRED FOR JOB COMPETENCE FOLLOWING ILLNESS/INJURY

Slide 35.

SUB-SETS OF SYMPTOM-RELATED PROBLEMS:

1. SENSORY-PERCEPTUAL DISTURBANCE
2. COGNITIVE DISTURBANCE
3. LANGUAGE RELATED DISTURBANCES
4. PRAXIC (MOTOR) DISTURBANCE
5. DISRUPTED EXECUTIVE FUNCTIONS

Slide 36.

IMPORTANT COMPONENTS OF THE PROCESS OF APPLIED BEHAVIORAL ANALYSIS:

SETTING

FREQUENCY/DURATION

ANTECEDENT INFLUENCES

CONSEQUENCES

Slide 37.

ANTECEDENT EVENTS THAT MAY LEAD TO PROBLEMATIC BEHAVIOR

EVENT CATEGORY	EXAMPLE
Cognitive	Impulsive cognitive set, failure to appreciate full ramifications of action
Affective	Feeling dysphoric on a particular day
Interpersonal	Low self-esteem with overreaction to ridicule
Situational	Repeat of same circumstances encountered last week
Imaginary	Fantasy of worst case scenario - "I'm sure I'll fail."
Biological	Lack of sleep the night before, and forgot morning medications

Slide 38.

EXCESSES

DEFICITS

ASSETS

Slide 39.

NESTED SKILLS APPROACH

Slide 40.

A FUNCTIONAL APPROACH TOWARD PSYCHOLOGICAL TESTING PROVIDES A DEFINITION OF:

1. INFORMATION PROCESSING STYLE
2. COGNITIVE STRENGTHS AND DEFICITS
3. PROBLEM SOLVING SKILLS
4. COPING RESOURCES
5. PERSONALITY STYLE

PSYCHOSOCIAL SUMMARY

Client Name ______________________ Evaluator ______________________________

ID Number _______________________ Agency _______________________________

Date ___________________________

Basic Environmental Supports

Does the client have an effective support system?

Family ____ Y ____ N

Peer ____ Y ____ N

Institutional ____ Y ____ N

Does the client maintain a stable residence? ____ Y ____ N

Is the client active with a MH provider? ____ Y ____ N

Specify corrective action if necessary:

____

____

____

Physical Health

Are there significant physical health problems? ____ Y ____ N

Describe (i.e., well-controlled, may complicate programming):

____

____

____

If indicated, is follow-up provided? ____ Y ____ N

Describe (i.e., where, by whom, how often):

____

____

____

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Chapter II

ASSESSMENT IN PSYCHIATRIC REHABILITATION

GREGORY T. SLOMKA, PH.D.

INTRODUCTION

Advances in biological psychiatry have appreciably improved the ability of patients with chronic psychiatric conditions to achieve more efficacious levels of symptom control. Despite improved symptom management the functional outcomes of these chronic conditions for many individuals present significant restrictions upon their capacity to meet the demands of fully independent and autonomous functioning. Conditions like schizophrenia, with early and incipient symptom formation beginning in adolescence, and evolving over the critical periods in which independence and autonomous functioning skills are developed and practiced, can be particularly devastating.

In addition, individuals with severe and chronic psychiatric conditions display varying degrees of impairment in personal, social and occupational adjustment (Brewin, et al, 1988). Further, physical disorders that have potential to limit adaptive competency frequently go undetected in populations with chronic psychiatric disabilities (Leeman, 1975; Koranyi, 1979; and Hall, 1980). Evidence of deficits in cognitive, perceptual, and motor performance have also been documented (Erikson & Binder, 1986; George & Neufeld, 1985). Thus, clients with chronic mental illness manifest not only major psychiatric symptoms but also varying degrees of impairment across a wide range of behaviors necessary for autonomous functioning.

The material presented in this chapter is based on the premise that a comprehensive assessment must be a prerequisite for treatment planning. A comprehensive assessment methodology identifies not only the client's strengths and deficits across a wide range of behaviors necessary for adaptive functioning in the community, but also helps to determine the most efficacious remediation strategies appropriate for each client. The supportive and maintenance rehabilitation practices (Bennett, 1988) required by individuals with severe and chronic psychiatric conditions necessitate a higher level of sophistication in an assessment practice and a capacity for ongoing evaluation than has previously been available.

DEFINITION OF PSYCHIATRIC REHABILITATION ASSESSMENT

Assessment in psychiatric rehabilitation can be broadly defined as a comprehensive, multidisciplinary process which provides relevant, objective information about the client. This methodology takes into account both retrospective and prospective information. It represents an ongoing process that continues over the course of intervention or treatment. Comprehensive assessment provides an overview of not only the client's current functional skills, but an examination of past performance history. It provides the information from which individualized rehabilitation goals will be developed, prioritized and evaluated. In addition to fulfilling a prescriptive function as the basis for treatment planning, results may also be utilized to help predict future client functioning and needs, as well as aid in defining resource allocations. McCue (unpublished manuscript) has provided definitional criteria for factors constituting psychiatric rehabilitation assessment standards. An expanded discussion of each criterion is presented below.

Assessment must be comprehensive. Data are gathered from as many sources as is necessary to gain as detailed a description of the client as possible. These sources include physical, behavioral, affective, social and vocational spheres.

Assessment is multidisciplinary. In order to effect a comprehensive evaluation, it is necessary to appropriate data from multiple sources. This includes obtaining retrospective and current reports on state of functioning. Typically, reports of medical, psychiatric and, when necessary, allied health professions are accrued. Psychoeducational test records can also be extremely valuable. Formal behavioral and functional assessments can contribute significantly toward specifying the needs of a client. There remains a plethora of other specialized evaluations which might be acquired depending upon other complications with which a client may present, e.g., ophthalmological, speech or audiological evaluations.

Why the emphasis on so wide a spectrum of assessment in clients with chronic mental illness? A review of health status helps illustrate this point. It is not uncommon to confront a number of primary and secondary health related problems in populations manifesting chronic psychopathology (Koranyi, 1979; Leeman, 1975; and Hall, 1980). Not only many nascent medical problems go undiagnosed in this population, but individuals with severe chronic disabilities also often display limited insight into the significance of their symptoms and consequently underreport them in clinical contacts. Certain of these conditions and their treatments have the potential to influence both mental status and general adaptive skill competencies. Aside from the identification of undiagnosed acute or chronic conditions, it is important to have knowledge of the client's general physical integrity. Physical limitations could influence factors such as stamina and length of time the client can be expected to participate in programming. Subtle conditions such as cardiac abnormalities or diabetes could substantially influence susceptibility to fatigue. Sensory impairment such as diminished visual acuity or reduced auditory efficiency can go unnoticed in patients with severe impairments.

Assessment should offer a longitudinal perspective of the client. The fact that we are dealing with a population manifesting chronic psychiatric disorders indicates that we may confront changes in baseline psychiatric status, e.g., acute or subacute exacerbations of symptomatology. Knowledge of the past course of the illness can be helpful in predicting and preventing recidivism, or at least in reducing its potential severity. There are also situations in which the client's present state of functioning represents a significant decline from a previous level of performance. The presence of pseudodementia in a client with severe, chronic, refractory depression is exemplary.

Knowledge of premorbid functioning has other predictive utility. Evidence of a stable premorbid history can be prognostically favorable and can implicate areas of strength which might be tapped in treatment. The patient with a "first break" symptom display followed by a period of stable recovery is regarded as significantly less vulnerable to decompensation than a patient with multiple recurrent bouts of severe psychiatric illness. Knowledge of patient treatment successes also is invaluable. Thus, there is a wealth of data available regarding the client if a panhistorical approach is adopted regarding information gathering.

Assessment is ongoing. In the context of service provision, the process of assessment in psychiatric rehabilitation is not a discrete or unitary function. Although the major investiture of effort is focused on the initial pre-treatment evaluation, the process of assessment is not limited to this phase of treatment planning or service provision. The progress of the client in treatment requires ongoing assessment to evaluate success in the attainment of goals and to modify intervention efforts to meet evolving needs. Unfortunately, these changes do not always reflect progress. Clients with chronic psychiatric conditions must be consistently evaluated for markers of potential deterioration because by the nature of their chronic condition, they are susceptible to decompensation. The attainment of success in one aspect of a program does not exclude the client from vulnerability to deterioration in another. Success in the vocational arena without subsequent improvement in social adaptation might lead to a stress-related decompensation which was triggered by the transfer of a work site or a promotion. Any major transition a client experiences has the potential to necessitate significant re-evaluation of needs.

Assessment must be undertaken in a systematic fashion. In reviewing the licensure or certification of psychiatric treatment programs, one is impressed with the degree to which reviewers focus on assurance of the development of adequate treatment plans. They place great emphasis on systematic treatment planning. It can be argued that a systematic approach towards assessment is as necessary as systematized treatment planning. The more structured and cohesive this process, the greater the probability that the formulation of intervention plans will meet the true individual needs of the client.

Systems vary in the formal structure they impose on assessment. In some instances, all clients pass through standardized "battery" of procedures. in others, the process is highly individualized according to client need. We lack systematized studies of outcomes of fixed versus flexible assessment strategies. Intuitively, beginning with brief multimodal assessments and focusing on more and more refined data collected based on identified need, holds obvious merit. In the planning of assessments, it is beneficial to control not only what should be assessed, but also how, when and by whom. If a client is served by multiple resources, it is necessary to centralize, guide and direct the procurement of assessment information to maintain efficient data accrual and to prevent duplications and gaps. A major aspect of good rehabilitation management is the coordination of such efforts.

THE CHANGING FRAME OF REFERENCE IN REHABILITATION ASSESSMENT

Traditional assessment methodologies of one to two decades ago were primarily concerned with the identification of traits, attitudes, behavior characteristics and the medical-diagnostic documentation of factors to support diagnostic and etiologic inferences. Contemporary rehabilitation needs force our evaluation efforts to be directed away from classificatory decision-making to strategies which focus more directly upon the description of environmental functioning and adaptation. We have experienced a paradigm shift from rehabilitation efforts steeped in a pathologically oriented view to a more optimistic problem-centered view that examines the dynamic characteristics of the individual and his/her environment. When the outcomes of assessment are examined in this context, it is easy to determine the relative efficacy of such information for treatment planning.

We can dichotomize orientations toward assessment on a continuum which at one extreme is focused on products or scores At the other extreme is an emphasis on the processes or strategies a client utilizes to solve tasks. The "nomothetic tradition" views testing as a means to use scores based on normative criteria for classification or discrimination purposes. An example of an inference derived from this orientation would be, "The client's two-point code on the MMPI is consistent with a diagnosis of Depression." Such a statement provides a limited yield for individuals interested in the day to day support of such a client. A modification of the nomothetic tradition, criterion referenced testing, offers some greater yield in the context of the prediction of outcome. Consider this predictive statement for example: "85% of clients who scored at or above this criterion score were successful in transitional employment." Outcome measures of this type have greater relevance for program planning.

The "idiographic tradition" represents an interest in the qualitative aspects of the behavior observed in testing. When used in combination with the known history, it provides a means to describe what is unique about that client as he or she engages in test activities. An example of such an inference would be, "While completing puzzle constructions the client brought to bear strengths in the verbal domain to help himself compensate for his visuo-motor defect." This information provided constructive information regarding a potential means to adapt training strategies based upon an inference derived about the client information processing style.

The examples cited above allow us to focus on two principal outcomes derived from testing: scores and observations. In the discussion which follows, we will attempt to reframe the utilization of traditional psychological assessment methodologies in a context which permits the furtherance of the description of relevant client attributes.

Technical Aspects of Assessment

Assessment is a comprehensive process of deriving meaning from test scores so as to achieve as broad and as detailed a description or understanding of the client as is necessary for the rehabilitation programming in question. Three basic challenges must be met in the description of any assessment methodology. The first set of demands refers to psychometric properties. Procedures must meet criteria for validity and reliability. The tools utilized to assess behavior should have demonstrable validity for measuring intended behaviors or traits. Reliability is also crucial. Data must be collected consistently across staffing patterns and varying test circumstances. Second, there are institutional constraints which place limits on the manpower, time, resources and settings in which assessments can be conducted. The third factor, utility, may, however, be the most crucial. The "utility" of any assessment methodology refers to how useful the derived data may be for decision making. We can extend this criterion to the concept of ecological validity, i.e., the ability of a test to go beyond ranking or categorizing behavior, so as to further our understanding of how specific patterns of strengths and weaknesses will contribute to an understanding of the client's daily functioning.

It is also important to emphasize that test results and observations alone are an insufficient basis for placement, treatment or diagnostic decisions. There is a whole universe of information available to complement this process: psychosocial history, medical and developmental history, functional evaluation of current life circumstances, available environmental supports, the nature of intercurrent stressors, etc.

It appears at first glance that the assimilation of a tremendous amount of information is required to conduct a comprehensive assessment. This is, indeed, true. There remains, however, the realities of time, resources and energy which limit the scope of the assessment process. The challenge in the development of assessment and data collection systems is the balance of accurate and reliable information from individual and institutional resources. In this regard, we must seriously entertain how additional assessment strategies might be modified to meet current needs. Rehabilitation, perhaps, oversimplistically conceived, represents a learning process; an effort to assist clients toward a meaningful reintegration with their community. Our success in this regard is very much determined by our capacity to make valid, appropriate and reliable assessments of the variables which will influence this process.

Contemporary treatment intervention and service demands further require that our methods be aimed more toward evaluating client's abilities and deficiencies in the environments in which they will function. Stated in yet another way, we are interested in defining the dynamic characteristics of the individual that will lead to success or failure in specific environments. Tests which lack generalizability outside the context of the consulting room have little meaning or relevance.

Regardless of the assessment methodologies utilized, be they traditional objective psychological tests or behaviorally anchored functional assessment procedures, the previously stated criterion of an **ecologically valid description** of client functioning must be fulfilled. In addition, the methodological criteria of reliability, validity and utility must also be met.

With this overview of basic assessment principles complete, we will turn to a discussion of traditional methods of psychological evaluation and attempt to explicate how greater functionally relevant information can be derived from these methods. In this process the following domains will be examined for their relative contribution to differential client description and rehabilitation planning: general ability level, information processing strengths/weaknesses, problem solving skills and coping resources.

TRADITIONAL METHODS OF PSYCHOLOGICAL TESTING APPLIED TO PSYCHIATRIC REHABILITATION

Intelligence Testing

Intelligence testing represents one of the earliest forms of psychological testing. It has traditionally focused on an end-product or outcome score, the intelligence quotient. This score has been utilized both as a means of classification and as a predictor of potential. One can, indeed, make some arbitrary inferences regarding potential outcome using a single molar score such as the IQ. For example, in considering two individuals with WAIS-R IQ's of 118 and 82 it is readily apparent which would have greater success in a professional occupation versus an unskilled labor position. We live, unfortunately, with biases which cause us to assume a specific cognitive set when we hear IQ score. This illustration emphasizes that a unitary conceptualization of intelligence based upon an IQ score alone could be very misleading. Intellectual processes are multidimensional in nature. We will, therefore focus this discussion on how intelligence testing can be utilized to describe differential ability and serve as a first order level of analysis regarding the identification of any specific deficiencies in information processing that could influence learning and adjustment.

THE WECHSLER INTELLIGENCE SCALES

The Wechsler Scales represent the most widely utilized tests of general intelligence. They exist in three forms: adult, child, and preschool versions (Wechsler, D., 1967; Wechsler, D., 1974; and Wechsler, D. 1981). They evolved from the Wechsler Bellevue Scale (Wechsler, D., 1944), the first instrument to utilize a deviation IQ score. This represented a departure from the model offered by the Stanford-Binet Intelligence Scale (Terman, L. and Merrill, M., 1960), in which the individual's performance was compared relative to his own age. The Wechsler model ranks standing relative to an age-matched normative population, a statistically more robust technique for describing intelligence over the course of development. The Wechsler Scales were also a radical departure from the Stanford Binet in that they permitted an opportunity for analyzing differential abilities via analysis of both subtest performance and the differences between overall Verbal and Performance IQ scores. In comparison to the Stanford-Binet, which offers only an IQ or Mental Age score, this expansion in coverage provides an important base for the pragmatic description of the client in terms of cognitive strengths and deficits.

Discussion of the Wechsler Scales will be limited to the adult version. The WAIS-R is an individually administered intelligence test consisting of eleven subtests: 6 Verbal and 5 Performance subtests (See Table 1). Full administration can take up to 90 minutes. The Verbal Subtests consist of tasks which tap verbal conceptual ability, practical judgment and reasoning, numerical reasoning, immediate auditory attention span, acquired knowledge and general verbal proficiency. The Performance subtests involve more visuoperceptual and visuomotor skills in task completion. Spatial and nonverbal reasoning skills are tapped in these tasks. In addition, demands are imposed for speed dependent performance on a number of these tests. Subtests are scored as Scaled Scores with a mean of 10 and standard deviation of 3. The WAIS-R also offers the more familiar deviation IQ score with a mean of 100 and a standard deviation of 15. Scores in the range of 90-109 are considered indicative of average intellectual ability.

Verbal Subtests

Information. This subtest consists of 29 factual questions arranged in order of increasing difficulty. They are reminiscent of "Trivial Pursuit" questions. The test measures an individual's mental alertness and foundation of factual knowl-

Table 1. The Wechsler Adult Intelligence Scale - Revised

Verbal Subtests	Performance Subtests
Information	Picture Completion
Comprehension	Picture Arrangement
Similarities	Block Design
Vocabulary	Object Assembly
Arithmetic	Digit Symbol
Digit Span	

edge concerning the world--knowledge that adults presumably acquire if given adequate educational opportunity. It requires intact long term memory and the ability to access remote factual material. Success on this subtest is associated with past education, social and cultural experience and literacy. Poor performance, therefore, could be due to poverty of educational opportunity, cultural experience or to low intelligence. For the most part, this subtest requires recall of facts; however, a few items do require analytic reasoning ability. It provides an index of knowledge available to the client for practical problem solving. If we consider intellectual ability reflecting the capacity to adapt knowledge in novel problem solving situations, performance on this subtest has the potential to influence adaption significantly. Defects in judgment and poverty in associational content may be seen in patients with psychiatric disabilities. This is exhibited not only in client's active symptoms, but also in individuals manifesting a more chronic debilitating course. Thus, noting any discrepancy between past levels of learning and ability to recall factual knowledge can be prognostically valuable.

Comprehension. This subtest consists of 16 questions of increasing difficulty, 13 of which test common sense judgement and practical reasoning, with the remaining three assessing the ability to interpret proverbs. The questions basically pose a conventional social situation and require a response. This subtest represents one measure of abstract verbal-conceptual ability. Like the Information subtest, Comprehension reflects the social and cultural background of the person tested. Long term memory is required, as is the ability to express ideas verbally.

Since the Comprehension subtest requires the use of inferences and judgments although limited in it breadth, this test does provide some insight into practical social problem solving. It also requires the client to provide more lengthy expository responses. It lends itself well therefore to the qualitative analysis of response content. Bizarre responses can give clues to psychopathology which might not have been observed clinically. Persons with schizophrenia for example may do poorly on this subtest because they often lack the intact judgment necessary to perform well. Their responses may be arbitrary, highly egocentric or concrete. High scores on Comprehension in persons with chronic and severe mental disorders usually suggest good reality contact and can be viewed as an index of stability.

Similarities. The Similarities subtest is made up of 14 items which require the individual to explain the commonality between two objects or concepts. The format is similar to other verbal analogy tasks in aptitude batteries. It is a test of logical thinking and verbal concept formation. Individuals must be able to generalize between two objects within a specific class. Responses usually fall into one of three categories: concrete, functional or abstract. Subjects respond to questions such as, "In what way are a screwdriver and hammer alike?" A "functional" response would identify a common use of the objects such as, "You fix things with both." A less sophisticated "concrete" response would be, "They both have handles." An "abstract" response to the same question would be "Tools." The more abstract the response, the better the score and the imputed general level of reasoning ability. The ability to work with abstract ideas and to see relationships is considered an important higher level cognitive skill for daily problem solving. Thus, this test offers an excellent measure of higher level intellectual abilities. Also, the test is useful because of its lesser dependence upon memory, educational experience, and cultural background.

In persons with significant psychiatric disorders, the complex cognitive skills required in this subtest are particularly sensitive to deterioration. A loss of "abstract attitude" has been commonly attributed to patients with chronic schizophrenia or brain damage. Persons with psychoses or affective disorders may do especially poorly on this subtest. Persons having depression may lack the energy to invest in the active problem solving demands associated with this test. Long term schizophrenic illness is reflected generally by quite concrete responses. More acute thought disorder would be reflected in unusual associational content or clang associations.

Vocabulary. The Vocabulary subtest is made up of words, hierarchically arranged in order of difficulty, which the individual is required to define. It is a measure of the ability to recall and express previously acquired word meanings. This measure of functional lexicon of knowledge is again strongly related to both educational and cultural experiences. This subtest is widely accepted as the best single estimate of general, as well as verbal intelligence. However, because of the likelihood of educational, as well as social and cultural biases, caution should be exercised in the exclusive use of Vocabulary as the sole predictor of baseline intelligence.

The Vocabulary subtest is considered a "hold" test. It tends to be relatively resistant to change in the face of age, cerebral dysfunction, or psychosis. It is, therefore considered as one means to estimate premorbid intellectual abilities. The Vocabulary subtest in limited circumstances can also aid in differentiating between persons with functional psychiatric disorders and those with organic disease. Persons with schizophrenia may have a tendency to let down their guard when faced with the relatively innocuous vocabulary tasks and thus expose evidence of a thought disorder as reflected by their poor judgment, idiosyncratic associations, or highly egocentric or confabulatory responses. They may miss very simple words, but be fully accurate with rather complex word meanings. The client with organic involvement tends to show more consistently concrete responses without unusual embellishments.

Arithmetic. The Arithmetic subtest consists of 14 mathematical statement problems presented orally and solved without benefit of pencil and paper. Responses are timed and bonus points are accrued for efficacious performance. The test primarily taps arithmetic reasoning ability. It does not exceed a seventh grade level of computational ability. Requisite skills for adequate performance include basic arithmetic proficiency, verbal comprehension, attention and immediate memory, logical reasoning and concentration. On more complex items, individuals are required to manipulate information so as to conduct complex multi-step operations. This latter ability is highly sensitive to psychopathological states such as anxiety or depression which can result in impaired concentration. Clients with attention deficit disorder would also be expected to perform very poorly on this subtest. It can serve as a gauge of active intercurrent thought disorder in that digressive reasoning, thought blocking and other cognitive difficulties would seriously impede performance. At a more pragmatic level, it provides insight regarding general efficiency in the types of day to day problem solving all individuals encounter.

Digit Span. The Digit Span subtest is divided into two components: Digits Forward and Digits Backward. Each component consists of random number series presented orally. The number of digits in each series increases with each item, from three to nine on Digits Forward and from two to eight on Digits Backward. In Digits Backward, the subject is required to reverse the order of digits mentally and repeat them backwards in this new format.

The Digit Span subtest requires immediate auditory attention, concentration, and memory. The reverse sequencing in Digits Backward requires greater cognitive flexibility because clients must not only hold information, but mentally manipulate it. Digit Span has been demonstrated to be very sensitive to both brain damage and anxiety. Persons with major depressive disorders tend to do poorly, as do persons with schizophrenia who have deteriorated. Individuals diagnosed with schizophrenia who are either cognitively intact or free of anxiety, however, perform relatively well on Digit Span. It is emphasized that Digit Span is not a formal test of memory, per se. It is a test of apperceptive span, i.e., attention. We find that even patients with Alzheimer's Disease who have severe memory impairment, can perform reasonably well on Digits Forward. At a more pragmatic level, this subtest gives some indication of how much information the client is immediately capable of acting on or incorporating. Weakness on this measure would show cause to examine carefully how much information is being presented to the client at any one time.

Performance Subtests

The Performance subtests of the WAIS-R are distinguished by their reliance on visual-perceptual, visual-motor and spatial reasoning skills for their completion. A substantial demand is made upon psychomotor integrity by the inclusion of speed dependent assembly tasks. A number of these tasks do focus primarily upon non-verbal as opposed to verbal reasoning skills in task completion. The Verbal-Performance dichotomy has led to a popular misconception of Verbal subtests as being exclusively language based, left hemisphere mediated cognitive operations, and the Performance subtests representing exclusively right hemisphere, visuospatial abilities. It will become readily apparent that verbal reasoning skills cannot be disassociated from a number of the Performance subtests.

Picture Completion. The Picture Completion subtest consists of 20 pictures in which the individual must identify a missing element under time constraints (20 seconds for each item). The test requires visual acuity, visual perception and scanning ability, and the capacity to differentiate essential from nonessential detail. The person must visually organize a gestalt or a conceptualization of the picture, attend and concentrate, and observe for inconsistencies or incongruities within the picture. Recall of information from long term memory and the ability to screen-out irrelevant information are the requisite skills for performance on this test. The content of the pictures, however, imparts a potential cultural bias which may have to be considered.

In populations with psychiatric disabilities, exemplary errors include bizarre responses from persons with schizophrenia and the frequent insistence from those exhibiting paranoid symptoms that there are, in fact no missing parts. Compromised performance is also reported in persons with schizophrenia who have deteriorated. Again, a dichotomy can be seen in error analysis between concrete-functional thinking versus abstract-conceptual ability. Weak attentional capacity, that is, inconsistent screening of the environment for relevant cues can also be inferred.

Picture Arrangement. Individuals are asked to arrange 10 sets of randomly presented cartoon pictures so that they tell a logical, coherent story. Story sequences are presented in sets of from three to six pictures which vary in the degree of difficulty and the complexity of the social situation involved. Bonus credits are awarded based upon speed of response. This subtest measures several major cognitive skills including visual acuity and perception, social awareness, planning skills, the ability to form and test hypotheses, and logicosequential reasoning. It is considered a measure both of general ability, as well social intelligence. Reliance upon interpretation of social consequences renders the subtest culturally biased for some populations because the test demands awareness of social conventionality. It is thought of as the nonverbal counterpart to the Comprehension subtest. Clients can, however, frequently be heard to verbalize to themselves while performing this subtest. As such, clients may frequently reveal compensation for what may be weak nonverbal or visual information processing ability. A helpful adjunct in test administration is a "testing of limits" procedure in which the client is asked, after completing the task, to explain the logic associated with his or her arrangement. This procedure helps elucidate defects in social judgments and reasoning.

Block Design. The Block Design subtest is perhaps the most recognized of the Performance subtests. It requires the individual to assemble nine different designs from cubes based upon a two dimensional model or template of a block arrangement. The blocks have two red sides, two white sides, and two sides that are half red and half white, split diagonally. Of the nine designs, the first four require designs derived from a 2 X 2 configuration, with the remainder requiring a more complex 3 X 3 arrangement. The test is considered the most stringent spatial reasoning task within the WAIS-R. It requires complex spatial analysis and synthesis at the perceptual level, as well as concerted visuo-motor integrational effort. Attention and concentration, reasoning, and motor integration skills are necessary to perform this part-to-whole constructional task efficiently.

This subtest has been demonstrated to be very sensitive to brain damage. Performance of persons with schizophrenia on the Block Design subtest tends to be relatively intact. In this regard, this subtest can offer a limited differential between functional schizophrenia and possible structural brain dysfunction.

Object Assembly. The Object Assembly subtest, another constructional task, is made up of four puzzles which the subject is required to assemble. Performance is scored for both time and accuracy. Object Assembly requires the ability to perceive and construct an object, not by using a model as in the Bock Design test (a copying task), but by making sense of, i.e., visually grasping complex elements and integrating them into a meaningful whole. Like the Block Design subtest, it is a measure of visuo-spatial integrational ability.

One must form visual concepts and quickly translate them into a motor response. This often requires cognitive flexibility and persistence in organizing and reorganizing under time constraints. Both persons with schizophrenia and brain damage may do poorly on this task. Because of the psychomotor speed demands required, persons with depression also tend to do poorly on Object Assembly. The effects of neuroleptic medication on psychomotor skills may also have a detrimental effect on performance. Significant discrepancies in performance favoring Block Design over Object Assembly have the functional implication of suggesting the client's enhanced potential to work from a "model" or "template" vs. independently. Task persistence and the capacity to engage in hypothesis testing efforts without giving up in frustration are relevant attributes to observe for on both Block Design and Object Assembly.

Digit Symbol. Digit Symbol is a coding or matching task performed under time constraints. The individual is asked to draw symbols in empty blocks below numbers (from 1 to 9) by using a code. It is the only paper-and-pencil task on the WAIS-R. Its associational task demands serve as an excellent measure of cognitive flexibility and efficiency, as the client must constantly shift cognitive sets. In addition to cognitive flexibility, problems with this subtest may also reflect motor problems. The complexity and speed determinants of this subtest make it highly susceptible to anxiety effects. It is also highly sensitive to brain dysfunction. Very good scores on this subtest contraindicate any effects associated with active severe psychopathology on cognitive efficiency.

Analyses of WAIS-R Performance

It can be readily seen that adopting a "process" oriented approach to the analysis of WAIS-R subtest performance can contribute significantly to a further understanding of information processing strengths and deficits unique to a client. In addition, there are three levels of quantitative analysis derived from the WAIS-R. First, is the derivation of the Full Scale IQ score, a general index of current functioning. In populations with chronic mental illness it is essential to understand whether current functioning represents any deterioration from a higher level of premorbid functioning. Evidence of deterioration immediately flags a need to ascertain what factors may contribute. We may be dealing with transient acute effects which tend to be reversible. There remains a possibility, however, of dementia in association with a long term chronic psychiatric disorder, especially in the schizophrenic spectrum disorders.

A second level of analysis involves any variability among the IQ scores. Is there any significant difference between the Verbal and Performance IQ? A discrepancy of 15 points or greater between the Verbal and Performance scores can implicate at a first-order analysis a relative strength or deficit between language and non-language based cognitive processes. For example, a low Verbal IQ in comparison to an above average Performance IQ suggests the potential to confront reduced abstract verbal-concentration ability, limited development of language-based academic skills, and potentially weak verbal memory. The opposite configuration, weaker Performance IQ, implicates the possibility of less adequate visuomotor integrational skills that could have a negative impact upon writing ability or constructional skills, non-verbal reasoning, math skills, or the capacity to deal with novelty or ambiguity. Visually mediated learning or instrumental skill learning may be weaker than verbally mediated learning strategies.

Finally, we can consider pattern analysis. A scaled score (on a scale of 1-20) is assigned each subtest based on relative performance. A scaled score of 10 (s.d.±3) is considered average. When subtest results are used, it is easy to plot the average of the combined Verbal and Performance subtest scores. Analysis is then undertaken of the clients' performance on each subtest relative to a standard based upon the Verbal and the Performance scaled score averages. Relative to the client's "own level of performance," scores 2-3 points over and above his/her average represent an area of special strengths; scores 2-3 points below average represent areas of distinct weakness.

A number of strategies have been developed to further the process of differential pattern analysis by moving beyond individual score variation to consider how specific clusters of subtests may vary. Very consistently, factor analytic studies have demonstrated three reliable clusters of subtest performance on the WAIS-R and WISC-R. Table 2 summarizes these results.

Table 2. Factor Structure of the WAIS-R

Factor	Subtests
Verbal Concept Formation	Information
	Comprehension
	Vocabulary
	Similarities
Freedom from Distractibility	Arithmetic
	Digit Span
Perceptual Organization	Block Design
	Object Assembly
	Picture Completion

The Information, Comprehension, Vocabulary, and Similarities subtests represent a Verbal Concept Formation cluster. Low scores across all four of these subtests are commonly associated with cultural disadvantage, developmental language disorders, learning disabilities, and academic underachievement. Considering the difficulty a patient with a psychiatric disability might have with formal thought organization, remembering that all four of these subtests make critical demands on expressive skills, one could look to these four scales as a means to assess quality of the formal organization of thought and communicative ability. There is also a Freedom from Distractibility factor which consists of the Arithmetic and Digit Span subtests. Attentional impairment and anxiety could selectively mitigate performance on these tests. In fact, this factor serves as a quite reliable indicator in attention deficit disorders in both children and adults. Finally there is the Perceptual-Integrative factor based on the visuo-perceptual, integrative, and motor assembly components of the Block Design, Object Assembly, and Picture Completion subtests.

A similar method of cluster analysis is the one proposed by Bannatyne (1974). This methodology has associated with it some demonstrated efficacy in the description of learning disability subtypes. The literature is replete with other combinations of WAIS-R subtest factors (Sattler, 1988). One must be careful with their application as many are based on clinical intuition rather than empirical validation.

It should be apparent to the reader that there is a wealth of data available from the WAIS-R that offers the opportunity to develop a number of heuristic assumptions about general ability and preferential styles of information processing that could have a potential impact upon general adaption, problem solving skills, and new learning. It is emphasized that the WAIS-R was validated as a general intelligence measure. The clinico-heuristic assumptions discussed above remain limited in their applicability. At this level of analysis they do not serve as sufficient grounds to base formalized treatment recommendations. They can, however, serve in: 1) documenting current functioning level, 2) providing a baseline measure against which past performance can be contrasted so as to determine positive or negative change in levels of performance, 3) adding yet another reference standard against which performance on academic skill measures or neuropsychological tests can be contrasted and 4) providing first-order level analysis hypotheses to guide and direct the direction of further testing.

While there are a number of other general and special ability measures which serve the function of documenting cognitive efficiency like the Stanford Binet IV, Peabody Picture Vocabulary Test, Raven's Standard Progressive Matrices Test, and Test of Nonverbal Intelligence, these latter measures lack the tradition the WAIS-R has enjoyed in ecological and outcome research studies across a variety of disability subtypes. Further, they lack the multidimensional descriptive utility of this instrument. It is not uncommon to see a number of the above measures incorporated as part of a larger neuropsychological test battery to further test hypothesis generated at the level of WAIS-R profile analysis.

ACHIEVEMENT TESTING

With consideration having been given to the assessment of the client's core cognitive facilities as measured by intelligence tests, we now turn to the examination of the functional implications of performance on achievement tests.

The diverse instruments which are available for this purpose take two basic forms: 1) comprehensive batteries which assess word recognition, spelling, arithmetic and reading comprehension; and 2) specialized batteries which focus in depth upon one area of academic skill function. The latter tests are typically applied only when a specific deficit in performance has been identified. These latter tests have greater relevancy for remedial and prescriptive educational intervention.

At this level of the assessment, the most common question confronting the client with chronic mental illness is, "What are the current or residual academic skill competencies displayed by the client relative to his or her measured level of intellectual functioning and psychiatric condition?" The documentation of intact and well developed academic skills is prognostically favorable. This indicates the client is essentially retaining previously learned material and is not encountering difficulties in day-to-day problem solving. For the client who was formerly employed, the prospects are unlikely that any supplemental basic educational supports will be required prior to occupational re-entry. Well developed fundamental literacy skills open up a broader range of training and educational options through the use of texts or other lexically driven self-instructional paradigms. The identification of any generalized or specific academic deficits can, however, be particularly problematic for rehabilitation planning. The approach toward intervention will focus on either remediation or compensation depending upon the careful specification of the nature of any identified academic skill deficits.

Consider how the approach to referral for academic skill training in two post-institutional clients with chronic mental illness might vary. The first referral involves a patient institutionalized intermittently for 20 years with no employment during this time, weak skills associated with independence and self-reliance, and poor money management skills. Premorbidly, normal intelligence and no school problems are noteworthy. The other patient presents with a similar scenario, but with a history of early, severe academic dysfunction and functional illiteracy. Both are en route to a residential treatment program. This question arises, "How would each client's individual functional academic deficits be remediated or compensated?" Who should be expected to gain in money management skills as a function of re-education versus who will have to be counseled to accept significant external supervision of personal funds? One client appears to need only intervention to compensate for lack of practice. The other will require more extensive special instructional intervention. To address such questions, it is necessary to transcend the simple reporting of grade equivalent scores on academic achievement measures. Rather, it is important to consider the potential ramifications of the client's current ability level and the demands incurred for academic skill proficiency across the settings in which he/she will function. The academic assessment database, thus, contributes one important source of information regarding how sophisticated a client may be in community survival skills.

When there is a variance between expected and actual levels of performance on achievement tests, the reason must be clearly ascertained before proceeding with interventions. This variance could result from a specific learning disability, underlying cerebral dysfunction, limited sociocultural and educational opportunities or underachievement. Scores on achievement tests are reported as grade equivalents, standard scores and percentiles. Knowledge of past performance, i.e., how far client went in school, his or her premorbid IQ, and his or her occupational experiences, offer opportunities to estimate premorbid levels of performance. The younger the client the more rehabilitation staff can rely upon grade equivalent scores. If the client had a 10th grade education, do his or her skills still cluster around that level? A psychometrically more valid means is to compare achievement test standard scores to an IQ score. Hence a client with an IQ of 104 and with a reading skill standard score of 84 is clearly impaired. Like Verbal-Performance IQ differences, disparities of 15 or more points between achievement test standard scores and IQ scores are considered clinically significant.

Achievement testing also provides information related to a client's general cognitive efficiency and the capacity to apply his or her knowledge in practical problem solving--an important consideration in community service planning. How well the client transcends simple calculation or reading recognition skills and attacks complex numerical reasoning or comprehension problems relates directly to the capacity to deal with practical problem solving in everyday living. Components of the functional assessment of community living skills should certainly be based on degree of primary academic skill competency manifest in the client. A firm foundation of knowledge about academic strengths and weaknesses also helps the counselor to distinguish between a lack of motivation or effort, and genuine learning problems. Knowledge of academic strengths and weaknesses can contribute not only to educational and vocational planning, but also to the prediction of the potential of therapeutic techniques. For example, strengths in reading and writing would support the use of bibliotherapy techniques, diaries or the self-recording of events associated with cognitive-behavior therapy techniques.

PERSONALITY ASSESSMENT

Accurate knowledge of core personality characteristics and the nature of a client's psychopathology is essential in both treatment and rehabilitation planning. Traditionally, personality assessment has been applied to aid in differential

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diagnosis. This discussion will focus instead upon how knowledge gained from personality assessment methodologies aids in the understanding of the client's adaption and coping skills. These factors are more germane to rehabilitation management and planning issues. Assessment conducted solely for purposes of diagnosis and classification as has been discussed contributes minimally to rehabilitation planning. It is not, however, necessary to abandon traditional methods of personality assessment because of this valid criticism. What is required is the reformulation of its products in constructs which are more meaningful for rehabilitation planning and management. Knowledge of the client's attributes in the following areas can be particularly beneficial in rehabilitation management: self-perception of individual attributes and deficits; tolerance for stress; preferred coping strategies; social and interpersonal skill functions; social comprehension and social judgment; and reality testing.

This process is accomplished through direct observation, obtaining third party ratings of behavior on questionnaires, or through self-report techniques. The first two techniques represent methodologies borrowed from applied behavioral analysis and will be discussed at length in the section which deals with Functional Assessment. Discussion will be limited in this context to the contribution of objective personality inventories in defining the above criteria.

Before actual personality assessment measures are described, it is necessary to consider two factors which distinguish personality assessment as a distinct methodology. The first factor involves the techniques used in the actual testing situation. When conducting personality assessments, we are evaluating samples of behavior objectively and in a standardized fashion, i.e., drawing inferences from normative criteria and then generalizing from this information. There are two types of personality assessment techniques: objective and projective methods. Objective tests consist of techniques which do not vary. Clients, regardless of circumstance, are rated across the same categories of behavior, beliefs, or attitudes. This applies to self-rating, as well as inventories which rely on third party ratings of behavior. Objective tests always culminate in scores which are compared against some criterion. This distinguishes them from projective techniques in which the patient is confronted with unstructured material and the responses are open-ended and thus, somewhat less amenable to objective scoring procedures.

The second factor to be emphasized in discussing personality assessment is that inherent in this process is the need for good clinical judgment. At one level of analysis we have objective results or scores. It is necessary, however, to combine these results with knowledge of the patient's past history, the clinician's theoretical orientation, and an analysis of the nuances personality factors and their relationships to pathological conditions. Personality assessment represents a fluid or dynamic process. Therefore, in a sense, all personality assessment is subjective. We tend to see a greater reliance on objective methods because they tend to better define the parameters of our decision making. With knowledge of a test's validity the clinician can be reasonably certain of the probability associated with conclusions drawn from that instrument. It is important to recall that the inferences derived from personality testing remain heuristic hypotheses that require further validation through our experience with the client. This information, combined with the clinical history can serve an important function in structuring rehabilitation planning decisions. The discussion of the application of two such objective personality assessment methodologies follows.

Minnesota Multiphasic Personality Inventory (MMPI). The MMPI, an objective personality instrument, was conceived in the 1940's as a means to assess degree and type of maladjustment. It is steeped in the conceptualization of psychopathology at that time which manifested a great interest in the identification of enduring personality traits (Dahlstrom, Welsh and Dahlstrom, 1972). The instrument consists of 566 true-false items. A reading comprehension level of sixth to eighth grade equivalence is required. There also exist alternate short forms of this instrument.

The administration of the MMPI culminates in a profile configuration plotted for 10 clinical scales and 3 validity scales. Scores are reported as T-scores with a mean of 50 standard deviation of 10. A score two standard deviations above the norm (T>70) is considered clinically significant. Interpretation is first based on consideration of the overall profile validity. A central question to be addressed before interpreting any objectivity inventory is, "What was the patient's response set while taking it?" On MMPI, three validity scales, L, F, and K are available to define the client's approach in responding. These scales help identify whether the patient is biasing his or her responses through excessive denial or exaggeration of symptomology. If extreme deviation is noted, the examiner must adjust his or her interpretation accordingly. If the validity scores are within normal limits, interpretation can proceed.

The most elemental interpretive strategy used with the MMPI are the two-point codes. The patient's two highest critically elevated scores are referenced in an interpretative manual or "cookbook" , and a description, relative to a normative comparison group, can be made of the special attributes and characteristics which patients with a similar profile share. Limiting the interpretation of the MMPI at this level of analysis offers little in the way of descriptive information that might be useful to an interdisciplinary team.

A more sophisticated interpretation of the MMPI is associated with exhaustive consideration of the validity scale profile topology; the overall clinical scale profile shape (did it represent an abnormal, neurotic, psychotic, character pathology, or an acute vs. chronic configuration?); the two point interpretive guide; a summarization of the implications of the scores for each scale; low score patterns and their significance; and finally, a consideration of the implications of the numerous research scales and their contributions to the understanding the client. The result is an enhanced description of not only predominant traits and symptoms that aid in differential diagnosis, but data which contribute to the formulation of hypotheses regarding preferred coping styles, potential for success in adaption, activity level, psycho-sexual concerns, and the quality of both intrapsychic life and interpersonal skills. The combination of this information, plus the known clinical history, facilitates the development of programmatic inferences regarding the level of necessary support and supervision, need for special accommodation, stress tolerance, etc.

Millon Clinical Multi-Axial Inventory (MCMI). We will briefly consider one other objective personality inventory, the MCMI (Millon, 1982). It, like the MMPI, represents a broad focused, multifactorial approach towards personality description. The MCMI is similar in many respects to the MMPI, but in its development Millon attempted to devise a shorter (178 item) and potentially more valid instrument, especially as pertains to contemporary notions of psychopathology. This effort culminated in an inventory in which 21 personality dimensions are profiled in a fashion somewhat akin to the MMPI. A primary focus of this instrument is, however, on the Axis II symptomology indicative of personality disorders. The MMPI is viewed as primarily focused on Axis I, primary mental disorder symptomology.

The emphasis of the MCMI is not exclusively on Axis II disorders. It also provides a description of varied symptom patterns which are not necessarily enduring or characterological, but rather reactive. These latter scales suggest what types of symptomology might be manifest when the patient's coping resources are seriously taxed. For example, is the patient likely to manifest primarily anxiety symptoms, revert to substance abuse, or regress into psychoticism when significantly stressed? Another way in which this instrument is helpful is in enlarging the clinical description of the patient. Taking Major Depression as an example, cardinal DSM III-R symptoms include: dysphoria, low energy, neurovegetative symptoms, etc. There are, however, unique attributes which differentiate individuals who share this diagnosis. The identification of the degree to which a patient with this diagnosis might also manifest a tendency toward somatic preoccupation, overdependence, passive-aggressiveness, psychoticism, or substance abuse would obviously influence case management decisions. The MCMI, with its focus on both enduring personality traits plus "reactive" symptomology, helps to enlarge the focus of critical behaviors around which the client may be monitored.

The objective personality inventories discussed above are representative of the class of multifactorial or multi-symptom techniques. A wide array of single symptom inventories are also available. These inventories provide more expansive coverage of a single condition like depression, anxiety or psychoticism. As these instruments contribute primarily to clinical and psychiatric versus rehabilitation management, we are restricting our discussion of them.

Projective Tests. We will only briefly touch on these tests as like the single symptom inventories, their merit appears to be associated more with the conduct of intensive psychotherapy rather than with the pragmatics of service coordination and case management. As previously discussed, these techniques rely upon ambiguous stimuli as opposed to the question and answer type formats of the MCMI or MMPI. In the application of these techniques, it is hoped the patient will reveal his or her inner conflicts, motives, drives, coping strategies, ego defenses, and reality testing abilities. The theoretical underpinnings of these techniques are based upon how the dynamics of early development shape the structure of the self, and, in turn, how they influence the way the patient organizes and perceives his/her world. These techniques provide a window into the phenomenology of the individual patient and a view of the genesis and development of psychopathological processes.

Examples of projective techniques include drawings: human figures or settings; or incomplete sentences: "Most times I wish I could______." or "Teachers made me feel______." The Rorschach Techniques (Exner, 1974) and the Thematic Apperception Test (TAT) (Bellack, 1986) represent the hallmarks of this methodology. An analysis of the perceptual functions associated with the inkblot material of the Rorschach remain a valuable technique for differential diagnosis of schizophrenic disturbance even though the conventional psychodynamic interpretations of the content have become questioned in a number of quarters. The TAT on the other hand, presents a more realistic visual stimuli to which the subject responds by making-up a story. These interpersonal scenes provide not only a window into the psychodynamics of the individual, but also can be pragmatically interpreted when used with patients with chronic mental illness as an index of residual social skills. Their ability to interpret complex social scenes and respond in conventional fashion can be quite prognostic. The identification of potential sources of conflict (e.g., parents and authority figures) can be valuable for treatment planning.

Functional Implications of Personality Assessment. Summarized below are a sampling of the more functionally oriented inferences that can be derived when applying personality assessment methodologies with patients who exhibit chronic and severe major psychiatric disorders:

- Definition of the severity of the disorder
- Definition of chronicity and possible course
- Identification of the prominent primary as well as secondary symptomology

- Identification of potential sources of conflict
- The provision of new hypotheses to be considered in furthering the understanding and treatment of the patient

It is not intended that the tests results alone are sufficient to develop predictive outcome statements. Personality assessment is a four stage process that involves: 1) a review of the relevant history, 2) a direct clinical interview, 3) an analysis of actual test data, and 4) when possible, the extension or modification of conclusions based on information derived either from third party sources familiar with the client or from direct observations. Family members and service providers can provide invaluable information regarding a client's actual adaptational and coping skills. As will be discussed in the Functional Assessment section, there have been a number of strategies developed to objectively evaluate social and interpersonal adjustment. Accrual of such data certainly extends the veracity of the inferences developed through the use of the more traditional measures described above.

NEUROPSYCHOLOGICAL EVALUATION

Introduction

Neuropsychological testing has been traditionally associated with the elucidation of the nature and significance of brain damage. Increasingly, the neuropsychological examination is no longer being utilized exclusively for the purposes of differential diagnosis, but to help guide and direct the development of rehabilitation strategies. In this discussion we will not specifically focus on the mechanism of brain damage per se, but on the cognitive and information processing strategies that are ultimately subserved by cerebral mechanisms and how these functions can be impaired in severe and chronic psychiatric conditions. Cognition in this context will be defined as "broadly pertaining to the encoding, transformation, storage, and use of information for the purposes of regulating behavior" (George & Neufeld, 1988 p. 264). Our operational principle, thus, stresses learning or skill acquisition and problem solving abilities underlying all rehabilitation strategies. The understanding of how cognitive and information processing skills may be compromised in clients manifesting severe psychiatric disabilities becomes an important determinant in the assessment of their potential to benefit from specific types of rehabilitation interventions. This section expands upon the data base derived from evaluations of both intelligence and academic achievement, as well as personality characteristics to include sensory, motor and diverse higher cognitive functions such as attention, memory, and complex problem solving abilities. In this fashion, it is possible to more specifically delineate the individual strengths and weaknesses of the client in learning and problem solving.

Rationale

According to Boll (1977) neuropsychological assessment is a form of human ability testing that is unique for its attempt to further the understanding of brain-behavior relationships in both normal and impaired individuals. The neuropsychological assessment of a population of individuals who manifest severe psychiatric conditions has a long history. This includes the study of the schizophrenic spectrum disorders, as well as depression and mania (Miller, 1975; Goldstein, 1978; Heaton, Baade & Johnson, 1978; Heaton & Crowley, 1981; and Flor-Henry, 1983). More recently, Townes, et. al. (1985) undertook an investigation of nearly 500 patients referred for psychiatric treatment and who subsequently received neuropsychological testing. Twenty-five neuropsychological variables were considered in a Q-type factor analysis of patient performance. Their results revealed five distinct subtypes of neuropsychological performance within this population. The subtypes included: no impairment, profound impairment, an intermediate group in which basic intellectual faculties were preserved but deficits in complex problem solving skills were delineated, and two additional groups in which some modality specific information processing deficits were exhibited, i.e., one group with weak visuospatial skills and the other with weak language faculties. Interestingly the neuropsychological subtypes were found to be independent of primary psychiatric diagnosis. This study has been cited frequently as the basis for a competency-based model of classification that allows for the matching of treatment intervention strategies to the unique cognitive ability structure of the client.

Thus, in chronic psychiatric conditions, in addition to deficits in thought process organization, communication skills, and behavior problems, a variety of underlying cognitive processing problems can also be exhibited. It has been the contention of a number of authors (Erikson & Binder, 1986; Yozawitz, 1986; and Liberman et al., 1986) that the cognitive and problem solving deficits inherent in these populations have ostensibly been ignored. A number of rehabilitation failures could be related to an inappropriate match between rehabilitation program expectations and the inherent cognitive ability structure of the client.

Neuropsychological Evaluation: Aims and Purposes

The neuropsychological evaluation is in many respects similar to standardized intelligence and achievement testing. Objective, standardized tests are administered and the results are scored relative to normative criteria. The hallmark of the neuropsychological tests is their validation as mechanisms to distinguish normal from impaired cerebral functioning. Hence, they have the capacity to allow for the development of inferences regarding the presence or absence of brain damage, the delineation of its location and severity, and more importantly, in the context of this discussion, the capacity to describe adaptive consequences for the individual undergoing evaluation.

A comprehensive neuropsychological test battery is typically composed of tests which tap basic sensory-perceptual faculties, psychomotor proficiency, higher level visuospatial integrative skills, constructional abilities, receptive and expressive language, attention, memory, and complex problem solving skills. Test batteries can be broadly conceptualized in three typologies: fixed batteries, flexible batteries, and the individualized or "patient-centered approach". Comprehensive approaches like the Halstead-Reitan Neuropsychological Battery (HRNB) (Reitan & Wolfson, 1985) or the Luria-Nebraska Neuropsychological Battery (LNNB) (Golden, Hammeke, & Purisch, 1980) are representative of the fixed battery tradition. Coverage is provided across a number of performance domains relevant for clinical decision making. The LNNB consists of 268 discrete test items which can generally be administered in less than 2 1/2 hours. Its structure and composition make it readily applicable for use even with persons moderately impaired by psychiatric illness. The HRNB, on the other hand, can take up to 6 to 8 hours to administer. It typically also includes the WAIS-R, achievement testing, and the MMPI. Many clinicians augment it with other tests they find particularly useful. It contains several major component tests, some of which demand 20-40 minutes to complete. Moderately impaired psychiatric populations who cannot tolerate extended attention and effort tend to do quite poorly. It is, however, recognized as an extremely valid means for diagnosing structurally based cerebral dysfunction.

The breadth of coverage afforded by these instruments exacts a toll in time, effort, and energy demands on the part of the client. A number of these procedures also do not lend themselves readily to test-retest paradigms essential for short term monitoring of client performance. In some instances, while a test may have high differential validity, its utility for rehabilitation planning with this population may not be obvious. More often, the neuropsychologist will tailor a battery of tests to meet presenting needs. This includes consideration of such extrinsic factors as the nature of the referral question, immediacy of need, past level of premorbid functioning, and intrinsic factors such as client stamina, tractability, frustration tolerance, sensory-perceptual integrity, etc. Proponents of this latter approach represent the flexible or individualized approach. Here, it is not uncommon to utilize a brief core or screening battery and expand testing differentially based on those findings. Yozawitz (1986) and Erickson & Binder (1986) provide exemplary core neuropsychological screening batteries adapted specifically for the assessment of clients with chronic and severe psychiatric disorders.

Functional Domains of Neuropsychological Performance and their Adaptive Implications

As indicated above, there are a number of performance domains assessed in a neuropsychological battery. Rather than recapitulating a list of tests relevant to the assessment of any of these dimensions, the current discussion will focus instead upon how inferences drawn from observed performances in these areas lead to an understanding of learning, problem-solving, and general adaption. Discussion will be structured along the lines of a hierarchal model of information processing. For example, Johnson & Mykelbust (1967) described the components of problem solving as a function of sensation, perception, memory, symbolization and conceptualization. A simpler heuristic model appropriate for understanding the implications of neuropsychological performance on everyday functioning would include input, consolidating, incorporating, and output. This model proposes a hierarchical organization of these skills as they refer to: input, the stage where information is first acted upon, i.e., primary information processing functions; processing or consolidation, the intermediate neuropsychological functions where active mediation of information occurs, i.e., information is assembled and made meaningful; an integration stage which requires input from working memory; and finally, executive functions which are brought to bear to guide and direct output or the products of cognitive activity. A discussion of each of the primary domains of neuropsychological assessment included within a comprehensive battery is provided along with examples of how these functions might be compromised by functional psychiatric conditions, and thus influence rehabilitation outcome.

Sensory-Perceptual Functions. In order for behavior to occur, sensory systems must activate. At this level of analysis, the rule-out of any limitations in visual, auditory, or tactile-sensory processing is necessary. Deficits in basic sensory input have the potential to drastically limit active information processing and thus, ultimately limit learning or adaption. Assessment typically begins with a coarse screening of visual and auditory faculties. Subtle problems with visual acuity while reading or failure to comprehend verbal instructions are not uncommon correlates of dysfunction at this level. It is not uncommon for staff to have experience with clients who have lost and not replaced eye glasses, fail to follow through on purchase of hearing aides, or to observe clients who are so unaware of such limitations that they do not seek consultations for the amelioration of these problems in the first place. Problems of this type typically represent peripheral rather than central nervous system related disturbances of perception.

Evidence of neglect, imperception, or suppressions would, however, suggest the potential for more cortically-based impairment. That is, information either is incompletely processed or not processed at all. These problems are typically lateralized, occurring only on one side of the body. Their most frequent cause is stroke. The frequency of such problems is typically very low, unless neurological problems are also part of the clinical picture. In populations with severe chronic psychiatric disabilities we tend to see a more subtle manifestation

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of a similar, but distinctly different phenomenon, that of attentional impairment. In this instance, sensory-perceptual facilities themselves are not impaired, but it is the client's selective capacity to orient and attend that is dysfunctional. Information processing is an active-directive process. That is, we must be aroused, focused and attentive in order to perceive. Particularly in severe or acute stages of illness, these faculties can be severely impaired by primary psychiatric symptoms. In clients diagnosed with schizophrenia, for example, the selective filtering mechanisms appear to be dysfunctional. The patient may be attending to internal autistic stimulation at the expense of losing information form the world at large. In more acute manifestations of this illness, active hallucinations impair on-going information processing. In severe anxiety disorders the patient's cognitive focus is often so limited by his obsessional ideation that the individual misinterprets events or misses the events entirely. Cognitive psychology has amply demonstrated how persons having depression interpret almost any situation as negative, denying the obvious positive aspects of events which occur in their lives.

Another important related factor to be determined is how much information the client is capable of processing at a given moment. The number of discrete bits of information in an auditory or visual modality that the patient can act upon could significantly affect his or her ability to benefit from complex instructional paradigms or to understand complex directions. Knowledge of such selective information processing problems would cause the rehabilitation specialist to minimize the complexity of instructions or directions. In other words, before embarking on psychoeducational or vocational planning it is advisable to know something of the client's ability to assimilate information.

Before closing our discussion of sensory-perceptual abilities, mention should be made of tactile-kinesthetic functions. Here we refer to how well the client interprets information presented on the skin. Tasks to measure tactile functions include finger localization, point and pressure sensitivity, graphesthesia (interpretation of symbols or shapes drawn on the skin), and stereognosis (identification of palpated three dimensional objects). You may ask what relevance such tasks hold? First the early development of writing and reading is a multi-sensory experience. A deficit in tactile or haptic (muscle or joint) feedback can seriously retard development of writing skills and, hence, contribute to an overall retardation of reading abilities. More germane to adult populations, however, would be deficits seen in quality control or assembly line work that are secondary to diminished tactile accuracy. Imagine a machinist or auto mechanic displaying such dysfunction. More personally, picture what it would be like to function with diminished perception of sharp-dull, hot-cold or rough-smooth, in terms of the work you do around your own home.

Psychomotor Skills. In this domain abilities measured include speed, dexterity, coordination, and strength. This includes not only upper-body and hand performance, but overall psychomotor integrity. A number of these procedures have been utilized in vocational evaluations. The Purdue Pegboard Test represents just such a commonly utilized methodology. In this test, the client is timed across 30 second intervals to measure how many pegs he or she can fit into holes using the right, left, or both hands simultaneously. Speed, dexterity, and coordination are assessed. Over the course of these and other exams, performance on the right side of the body relative to the left is contrasted. A right hand dominant individual should perform motor tasks with greater proficiency as compared to the left. Asymmetries and discrepancies from this expected performance pattern become the object of further investigation. Early developmental or acquired cerebral dysfunction could contribute to such performance asymmetries.

When compared against norms, performance across tests of psychomotor integrity can be particularly helpful in vocational decision making. For example, the Purdue Pegboard Test provides an indicator of the average performance of industrial assembly line workers. This gives some indication of the patient's performance relative to the standards in the field. When assessing psychomotor skills, we are also interested in the ability to carry out complex motor programs. Here, planning, regulation, and modification of performance in the face of changing feedback becomes more involved.

From an applied rehabilitation perspective there are a number of potential findings which are of significance. For example, motor slowing is not necessarily evidence of structurally based central nervous system dysfunction. The effects of neuroleptic medications on the extrapyramidal system can limit performance. Psychomotor slowing is a prevalent symptom associated with depression. Motor impersistence or fine control and regulation problems are frequently manifest in patients exhibiting hypomanic symptoms. Tremor from anxiety can significantly mitigate skilled movements. We can see evidence of diminished strength in persons who have been chronically institutionalized and who have not been sufficiently stimulated or have failed to maintain muscle tone. These individuals typically require work hardening programs before they can engage in demanding programming. Multisystemic medical disorders could also exert an influence on performance. Finally, we sometimes confront patients who can perform discrete skills adequately, but cannot integrate these skills into a series of complex behavioral sequences. A deficit in executive functions secondary to defect state schizophrenia might result in such difficulties with complex motor programming.

Spatial Integrative and Constructional Skills. As we move up the scale in level of complexity from primary sensory-perceptual and psychomotor functions, we encounter tasks which require the integration of visual, spatial and motor skills. Spatial disorientation refers to any defect in the ability to relate to position, direction, or movement of an object in space. This relates pragmatically to real world functions such as right-left orientation, body schema organization, directional sense, distance estimation, and topographical orientation. At a first level of analysis these tasks are assessed via mechanisms which require mental manipulation or revisualization skills.

These processes become much more complex when we add a motor or constructional component to the problem solving task. Here, reference back to the discussion of the Block Design and Object Assembly subtests of the WAIS-R is in order. Observation of a client's performance on such tasks offers important insights regarding visuo-spatial conceptualization skills, problem solving style (orderliness and planning), and speed. Qualitatively we note the sophistication, thinking processes, temperament, impulse control, and self-attitude manifested by the client. These subtests provide an excellent opportunity to observe work habits under challenging conditions A further function of assessment in this domain is to rule-out any secondary developmental information processing difficulties, distinct from the CMI condition, that could limit adaption, e.g., a non-verbal learning disability.

Language Functions. Aphasia examination represents a mainstay of the neuropsychological evaluation. Proficiency in both expressive and receptive language skills is assessed under conditions of varying complexity. The components of this examination include spontaneous speech, repetition, comprehension, naming, reading, and writing. Combinations of deficits in these areas form the basis for the differential diagnosis of aphasic syndromes. The base rates for specific aphasic syndromes in this population is low. Evaluation in this area is, nonetheless, extremely useful.

Language serves as the basis both for thought (internal communication), as well as for speech, our primary means of communication with the world at large. Both schizophrenia and depression are noteworthy for exerting both subtle and profound influences on communicative effectiveness. Neuropsychological testing offers a unique and unobtrusive medium to examine for such effects. In terms of the pragmatic utilization of language, we look first towards the communicative efficiency of expressive language. Is speech articulated clearly, well formed, and fluent? Does it conform to the general rules applied to language use, i.e., grammar and syntax? How sophisticated is it in terms of organization, complexity and coherence. A fundamental question in terms of functional ramifications is: How well do expressive language functions translate into the patient's ability to articulate his or her personal and social needs and enable him or her to communicate with the world at large?

We look in similar fashion at receptive language faculties. Can the client understand progressively more complex verbal material? (From phonemes, to words, to phrases, to sentences and interrogatives which contain complex relative, attributive and comparative structures). These lines of inquiry focus on how well the client can take directions, how complex these directions can be, and what special learning paradigms will need to be incorporated into training to compensate for any identified weaknesses in receptive language faculties.

Memory and Attention. These facilities refer to the ability to acquire new information, organize it, encode it into long term memory store, and retrieve it. Information must first be actively processed if it is to be learned. We are not passive receptors of sensory information. We select that to which we wish to attend. We filter and augment sensory information based on our personal and experiential histories. Before we can even consider memory efficiency, the first order of analysis is the rule-out of any dysfunction in attention or decreased motivation as factors limiting performance. Here, we assess for the presence or absence of any modality specific sensory dysfunction, general or specific attention deficit disorder, effects of functional psychopathology, or amotivational symptoms. Depression, schizophrenia, dysthymic disorders, and anxiety and phobic disorders can all affect selective filtering mechanisms. We can conceive of this on a continuum of subtle through severe effects. A subtle effect might be reflected in depressive thought where negative introjects contaminate the interpretation of information. The patient is convinced of his or her low self-worth and selectively refutes any evidence to the contrary in his or her thinking. Hence, performance suffers. Moderate impairment may be seen in the obsessional client who is missing relevant information about his life circumstances secondary to his or her "myopic" preoccupation with trivial concerns. Such a client might answer current events questions incorrectly due to lack of awareness. The obvious worst case scenario would be the client who exhibits impaired reality contact associated with schizophrenia. It is not uncommon to confront serious errors on temporal orientation questions in the acutely symptomatic patient.

With attentional faculties given due consideration, memory processes can next be considered. Memory is generally assessed across three stages: immediate (attention), short term (new learning), and long term (remote). Memory is assessed in a modality specific fashion; that is, the rule-out of any differential strengths or weaknesses in verbal, visual, spatial, and tactile-sensory memory. This helps define areas of learning which might be either emphasized or limited in training. We are also interested in encoding strategies, i.e., those activities the client uses to organize, categorize, and semantically or visually structure material that is to be learned. We attempt to ascertain what, if any, strategies might be applied to augment memory organization. These faculties all relate to new learning or short term memory strategies. Remote memory refers to the ability to recall or retrieve previously learned material from memory stores.

Therefore, it is important to assess recall of relevant material that might be based on educational experiences, as well as the client's personal history. Thus, we can see that dysfunction which occurs in memory can occur at a number of levels.

One does not expect to confront classical amnestic states (organic memory disorders) when evaluating the rehabilitation of clients with chronic mental disorders. The exception to this might be a history of head trauma or long term alcoholism as comorbidity factors. Rather, the emphasis is generally placed upon how impaired attentional capacity secondary to functional psychopathology can impede memory and new learning.

Complex Problem Solving Skills. Under the rubric of this heading are included proficiencies in the application of intelligence and academic skill competency in problem solving. Since this material has already been discussed, this section describes a more limited set of higher cognitive operations which are critical for autonomous functioning. Here, the focus will be on complex, simultaneous, and sequential cognitive operations and the executive functions.

As a patient interacts with the social world, he or she is confronted with tasks which demand cognitive flexibility, speed and efficiency, the ability to identify concepts and to apply novel reasoning, the ability to perform in the face of changing circumstances, and the ability to recall incidental material from the past to aid in contemporary problem solving. A wide variety of neuropsychological tests involve challenges for the integration of a variety of information processing and problem solving skills. Examples include the Category Tests (Halstead, 1947), Wisconsin Card Sorting Test (Berg, 1948), Raven's Standard Progressive Matrices Test (Raven, 1960), Trail Making Tests (Reitan & Wolfson, 1985), etc.

An individual is also expected to exhibit broad-based, self-regulating capacities necessary for sustained goal-directed behavior. These capacities include: planning, self-monitoring, the use of internal language mediation, motor control, and cognitively-mediated, goal-directed behavior. As can be seen these processes overlap with several of the neurocognitive capacities previously described. These executive functions are included as a separate category because together these procedures characterize the client's ability to employ active cognitive strategies in an on-going and adaptive manner. Tests, at this level of analysis, contribute to knowledge of the client's "metacognitive" processing abilities.

Deficits in these executive functions can frequently be encountered in chronic psychiatric conditions, especially schizophrenia (Pogue-Geile & Zubin, 1988). If one contrasts deficits commonly encountered in defect-state schizophrenia and the behavioral dysregulation of clients with frontal lobe damage sustained in head injury, a number of commonalities are apparent: defects in long term planning; diminished skills for self-evaluation; weak selective attention; problems with the ability to inhibit impulsive behavior; problems with complex integration and understanding of the physical, social and psychological worlds and deficits in the planning and regulation of motor behavior

Patients who have sustained severe traumatic brain injury pose a number of substantial rehabilitation challenges within the community after their acute care needs are met. While clients can be trained in discrete skills, their ability to carry-out these skills effectively and autonomously within the community has remained typically impaired. Defects in forming goals, planning, and the monitoring of behavior may be confronted. These defects in self-regulation and self-direction are similar to those that are manifest by clients having long term mental illness, especially those having long years of debilitating schizophrenic illness. It is interesting to note that a great deal of theoretical conjecture has focused on whether or not schizophrenia can indeed be explicable as a form of frontal system pathology. The purpose of this discussion is not conjectural, but pragmatic. What can we derive from this comparison? The premise advanced in this discussion is that neuropsychological testing offers insights into cognitive factors which may underlie or may be associated with least some of the functional deficits seen in clients with chronic mental illness. Whether or not these cognitive deficits are secondary to underlying cerebral dysfunction or are a component of the neuropsychiatric disorder, their effects upon adaption are significant and they need to be considered in rehabilitation planning.

SUMMARY

This section has offered both a description and a redefinition of traditional assessment techniques. Effort was made to focus upon the cognitive and information processing deficits which may underlie forms of chronic mental disorder and which may contribute to limitations in instrumental task performance. In addition, a rationale for "process oriented vs. psychometric approach" toward assessment was discussed. Functional assessment methodologies will be considered next.

FUNCTIONAL ASSESSMENT

Introduction

Traditional forms of psychometric assessment have generally been directed at native ability or capacity, i.e., measures of inherent ability. This reflects a tradition in testing which was established in the 1950's. Measures of general ability such as intelligence and aptitude tests have been increasingly questioned in regard to their ability to predict outcomes with specific clinical populations. Over the years questions have been consistently raised regarding the significance of scores on any psychometric test to predict the ability of persons having disabilities to adapt in the community.

It was perhaps within the tradition of services for persons diagnosed with

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mental retardation that this question was most poignantly raised. Traditional assessment with this population relied heavily upon the evaluation of formal intelligence with little consideration of other factors. With mandates for least restrictive treatment alternatives and the development of community-based treatment services came an awareness of glaring discrepancies in the ability of traditional assessment technologies to aid in treatment and service planning. An anti-psychometric movement in conjunction with the burgeoning development of "behaviorism" arose within some quarters of the field of the developmental disabilities. Central in this regard was the criticism that traditional testing led only to the generation of generic labels, i.e., "Moderate Mental Retardation." Assessment solely for diagnostic or classification purposes was viewed as counterproductive, since it demonstrated little benefit for advancing the predictive potential of individual rehabilitation efforts.

Within this zeitgeist, the emergence and subsequent development of a radically different assessment technology, functional assessment, occurred. In only a few years over 125 functional instruments were developed. These instruments purport to increase treatment planning efficacy by refocusing the assessment process upon the pragmatic evaluation of individual strengths and weaknesses that a client might show in his or her adaptation to specific environmental contexts. Dichotomous camps of those who held rigidly to "traditional assessment" and those who ignored this source of data only to focus on outcome measures of adaptive skill competency developed.

In their landmark text **Mental Deficiency**, Clarke and Clarke (1976), offered reapproachment. Summarized below is their integrative definition of "assessment:"

Assessment....

1. Describes an individual at a particular point in their development of intellectual, social, emotional, educational and allied variables with reference to a normative or contrast population.
2. Predicts performance of an individual at a future point in time.
3. Provides a profile of assets and deficits in order to determine the starting point for further intervention.
4. Provides an objective means to monitor progress over time (p. 371)

Both systems or philosophies of assessment were recognized as having relevance to the total description of the client.

The field of psychiatric rehabilitation has also seen the evolution of functionally based systems of assessment guiding and directing intervention. The literature has reflected that in terms of outcome, traditional applications of psychodiagnostic assessment methodologies did not correlate with eventual vocational or community adjustment outcomes, or contribute to the elucidation of skills requisite for overall community adjustment. Testing conducted purely for classification purposes shed no light on the individual variability so frequently seen among individuals sharing the same diagnosis. Ratings of personal, social, and work adjustment have, however, helped to describe how individual differences affect outcome.

A goal of psychiatric rehabilitation is to assure that an individual with a psychiatric disability can perform those skills necessary to live, work and learn in his or her community with the least amount of support (Anthony et al.,1990). Persons with psychiatric disabilities must be able to perform certain functional skills in order to maintain themselves independently in the community or to become re-integrated into the community at large. This is accomplished through two basic forms of interventions: 1) teaching clients the skills necessary to function as independently as possible, and 2) developing community and environmental resources necessary to support or strengthen the functioning of clients who fall short of independence. Functional assessment methodologies provide not only a basis for individual prescriptive treatment planning, but also offer a means of addressing various systems-related concerns, such as evaluating intervention effectiveness, monitoring outcomes, and planning for anticipated needs. The remainder of this discussion will focus upon functional assessment issues as they pertain to individuals with chronic mental illness. The need to rely upon not one single modality for assessment, but to incorporate functional assessment methodologies into a larger framework of comprehensive interdisciplinary evaluation, will be emphasized throughout this discussion.

THE DEFINITION AND USES OF FUNCTIONAL ASSESSMENT

Simply defined, functional assessment is the measurement of what a person can and cannot do. That is, the elucidation of behavioral strengths and weaknesses as they relate to particular goals. It is undertaken to aid in determining the impact of physical and mental impairments on behavior. Functional assessment offers a broad range of potentially useful information in the treatment of persons with chronic mental illness. A comprehensive functional assessment allows for the :

a) specification of both abilities and limitations in terms of self care and instrumental skill functions;
b) identification of the presence or absence of social and interpersonal skill deficits and strengths;
c) identification of remediation, training, or compensation techniques; and
d) identification of educational, vocational and community support needs.

Strategies utilized in the process of functional assessment vary considerably both in terms of methodology and content. These strategies include both formal and informal techniques. In terms of informal techniques, the presenting background history and psychological test history provide a rich source of anecdotal information which is pertinent to the formation of impressions about functional skill integrity. In particular, psychoeducational, medical, and psychological test reports that provide expanded discussion of pertinent observations about performance, as well as scores, can be quite helpful. Third party reports of functional abilities and needed resources may be acquired from family members, professional colleagues, or others knowledgeable about the client's skills. These types of information can often serve as a springboard for the development of more formalized assessment techniques. Caution is raised, however, regarding the unsystematic use of information acquired in this fashion because such information lacks objectivity.

THE METHODOLOGIES OF FUNCTIONAL ASSESSMENT

Within the context of "formal" functional assessment methodologies, rating scales or questionnaires are often considered in the forefront, as these are the most prevalent and readily available techniques. They represent, however, but one methodology available for use in functional assessment. Four distinct models can be applied to the functional assessment process (Liberman, 1982).

Table 3. Methods of Functional Assessment

Table 3. Methods of Functional Assessment
Behavioral Interviewing
Direct Observation
Self-Observation
Checklists, Questionnaires, and Rating Scales

Behavioral Interviewing Techniques. In this methodology, clients are asked to provide direct or personal descriptions of their assets, deficits, and possible excesses in terms of critical incidents or behaviors. Some interviewers utilize a structured interview schedule; that is, all clients assessed would be screened across the same set of questions. Other practitioners are far less structured and utilize behavioral interviewing techniques within the context of a more open-ended, problem-centered interview. A prototypic structured interview, the Vineland Adaptive Behavior Scale (Sparrow, Balla, & Cicchetti, 1984), utilizes a formal questionnaire (rating scale) as the basis for the interview. The interviewer does not simply ask a respondent to rate behavior item by item, but rather seeks descriptions of client ability across varied settings, and then utilizes this information to later rate and quantify items on the behavioral questionnaire.

Many clinicians favor the behavioral interviewing methodology for a number of obvious reasons. It "personalizes" the assessment experience and increases the personal role of the client in treatment planning. Critical behavioral issues can be immediately explored in terms of a hierarchy: "What"..."When"..."Where"... and "How" so as to obtain knowledge of contingencies and reinforcers that may maintain or preclude specific behaviors. Behavioral interviewing also lends itself to refocusing the client upon phenomenological issues, i.e., what he or she may be doing, thinking, or feeling in specific situations. This process facilitates opportunities for the client to gain insight into those factors which may be contributing to his or her condition. Finally, in such a process the patient is in an excellent position to aid in hierarchically organizing "strengths" and "needs" lists. The prioritization of intervention goals becomes a personalized experience for the client. For the clinician, factors which interfere with the development of insights become immediately recognized and can become the object of further counseling interventions.

Direct Observation Techniques. One of the most potent means available for functional assessment is direct observation. Here, the client is directly observed "in vivo" or in simulated experiences and his or her behavior is critically evaluated. An example of this can be seen in the work of the occupational therapists. In order to assess lunch making skills, for example, the client can be taken to an equipped kitchen facility and directly observed across a number of variables which include planning, organization, technique and outcome. Although direct observation represents both the most valid and reliable means of behavioral assessment, it is also the most costly in terms of manpower and resource utilization.

Typically, time-sample event recording offers a more efficient means to achieve the same purpose. Within a particular setting, at specified time intervals, objectified behaviors can be observed across parameters such as presence-absence, frequency, duration or intensity. In this fashion, multiple staff members could assume some responsibility for observation and recording of relevant data, thus making the process less labor intensive. Handbooks of behavior therapy (for example, Rimm & Masters 1977), are usually replete with examples of how direct observation and recording techniques can be implemented to evaluate behavior. It is often staff ingenuity that contributes more to novel applications of this type of assessment than technical manuals.

Self-Observation Techniques. A related, but frequently ignored methodology borrows many of the time or event-sampling techniques of observational strategies, but uses the client to monitor the identified behavior. For example, at specified time intervals, the client takes a behavioral "self-examination", and enters data. These techniques are particularly valuable for cumulatively monitoring behavior over protracted time periods. Improvement of personal attention to appearance and hygiene represent categories of behavior well suited to this technique. In addition, log books, diaries and event counters (frequency tallies) might be utilized. Central in this methodology is the opportunity for the client to gain experience in actively self-monitoring behavior. In many persons with chronic mental illness, a deficit in the ability to self monitor behavior represents a primary impediment toward gaining greater social and community acceptance. The greater assimilation on the part of the client of critical self-appraisal skills rather than reliance on third party evaluations offers an important barometer of autonomy and potential for success in independent living.

Checklists, Questionnaires, Rating Scales. Functional assessment inventories offer a number of distinct advantages in terms of feasibility, breadth of coverage, and economy of application. A number of instruments have been developed and applied across diverse treatment settings. They vary considerably in both length and breadth of coverage. In this paradigm, various behaviors are evaluated for presence-absence, quantity, frequency, etc. Inventories exist in a number of forms. Ratings may be provided by third parties familiar with the client, such as staff or family. Equivalent forms exist where the client rates his or her own behavior as well. There are instruments which focus exclusively around limited aspects of adaptive functioning, such as vocational skill competencies or selfcare skills, while others provide more global ratings across a number of disparate behavioral categories. Acker, 1990; Wallace, 1986; Green & Gracely, 1987; and Weisman, 1975, provide reference to a diverse sampling of functional rating scales applicable across a number of patient groups.

Despite the apparent diversity and availability of standardized rating scales, there remain a number of practical limitations associated with their use. Practitioners frequently report lack of sufficient specificity of the material sampled in comparison to the environmental contexts in which their clients function. An instrument might under- or over-sample particular categories of behavior. Those which provide quantitative scores based on normative standardization frequently suffer from restrictive parameters associated with the reference population in question. An example of this is seen in the application of a prototypical functional inventory which is used for persons who are mentally retarded, the Adaptive Behavior Scale (Nihira, Foster, Shellhaas, & Leland, 1974). The normative base for this instrument were clients who were institutionally served rather than those who had exclusively been served in community-based programs. Although one of the most frequently cited assessment instruments in use with this population, it remains restricted in its normative application because of its standardization on institutionally served clients.

Despite these limitations, the rating scale methodology serves a very valuable function in initial case management and service planning by providing a checklist for identification of presence or absence of critical skills. In terms of aiding in the monitoring of treatment or service interventions, rating scales and checklists can serve as a basis for pre-and post-intervention measures of performance and thus serve as valuable criteria for outcome measurement. An ideal instrument would offer not only an indication of the "presence or absence" of critical skills, but also the provision of scales which permit objective rating of the frequency of occurrence of targeted skills and the severity of behavioral deficits or maladaptive behaviors. As the development of inventories becomes more refined, we should see improvements particularly in this latter direction.

There remains yet another alternative for the practitioner of functional assessment, that of the development of unique, environmentally or programmatically specific instruments. A sampling of standardized inventories can be accomplished along with an inventory of behaviors considered critical within a specific environmental context. Agency or program specific rating scales can be developed as hybrids of other assessment tools. Such measures offer the potential to better serve individual programmatic interventions and needs. It is also quite reasonable to attempt local normatization of such instruments, or to attempt development of criterion validation. An example of this might be the determination that 80% of clients who scored above a specific rating scale score were also successful in transferring to a higher level of programming. In such a scenario, an outcome measure on a rating scale becomes one of the critical factors evaluated in the process of determining readiness for programmatic advancement. Thus, instrumentation serves the purpose of not only identifying targets for intervention, but also as a criterion measure in evaluating outcomes and service planning.

GENERAL PRINCIPLES OF FUNCTIONAL ASSESSMENT

Regardless of the methodology utilized for obtaining information regarding client assets and liabilities, there are certain general principles which can be applied in conducting the assessment and extending this information into generalizations appropriate for treatment or service planning. Cohen and Anthony (1984) provide a number of practical recommendations in this regard. A number of principles have been adapted and expanded upon for this discussion. Adherence to these principles helps to assure that functional assessment will be both meaningful and practical

Functional assessment must relate to an overall rehabilitation goal that is environmentally specific. The objective of assessment is to gain an understanding of the client's assets and liabilities as they relate to skill demands that are likely to be confronted within particular environments. The needs of the client may vary significantly across the settings in which he or she functions, i.e., the residential, the vocational program or work place, or educational and recreational programs. Assessment must, therefore, be "context specific." The evaluator cannot presume that a strength or deficit observed in one environment will necessarily transfer across program boundaries. A central problem confronted in dealing with persons with long term mental illness is the possibility that newly learned skills may not generalize across contexts. It is therefore important for the evaluator to consider actively the number of domains in which a particular behavior might have to be assessed. The principle further reinforces the concept of "ecological validity" discussed earlier.

Environmental specificity is also significant because it is this feature which distinguishes functional assessment from more traditional forms of psychometric assessment. Traditional psychological assessment provides general descriptions of cognitive performance and personality attributes. These descriptions are gathered within the context of a rather unique social and environmental circumstance--the consulting room. Inferences are drawn and generalized to the broader environment based upon objective results and impressions gathered in this context. Traditional psychological assessment does not, however, provide an opportunity to assess behavior as a function of the environment in which it occurs or to extend generalizations by specifying how behavior may differ across environments. Functional assessment, on the other hand, offers a means to assess behavior with "situational specificity." It thereby offers an excellent medium by which to extend the results or inferences derived from more traditional assessment methodologies. Utilization of both types of assessment, is, therefore, highly recommended.

The language of functional assessment must be behaviorally defined. A "skill" represents a set of behaviors that are both observable and measurable, and therefore, "teachable." If we as evaluators are going to translate successfully observations of client performance into statements which program staff can act upon, we must convey this information in objective terms. If we are going to attempt to monitor client change, our observations must be in terms which are measurable. The "Rule of the W's" is an aid in conceptualizing behavior in this fashion. Behaviors must be defined by WHO is performing it, WHAT behavior is the focus of the intervention as well as by the circumstances associated with the behavior--the (WHERE, WHEN, and with WHOM). These statements are advanced "positively" and in a language of "doing." Expectations for both the client and support personnel are clearly delineated in terms of issues of "personal responsibility."

Functional assessment is always individualized. Clients carry with them a unique and distinct phenomenology which sets them apart from every other individual. Too often the utilization of a stereotyped approach to behavioral assessment and treatment planning results in the re-application of fixed formulations of problems and interventions. Too rigid an adherence to a mechanistic formulation of skill deficits that does not take into account "personal" variables can result in treatment failure.

An example of this problem can be illustrated by considering the implications of the development of enuresis in a client. The sudden emergence of this problem in a client recently transferred to a new setting could signal any one of a number of possible underlying etiologies that would influence eventual treatment. So often in an exclusively "behaviorally oriented" functional assessment methodology there is a tendency to view outcome behavior to the exclusion of potential cause. In this case, the manifest behavior could have its basis in a functional etiology i.e., anxiety related to the transfer. From a psychodynamic perspective, enuresis could represent regression to more primitive behavior in the face of weak ego defenses that have been challenged. From a behavioral perspective this same symptom could represent a manifestation of "learned helplessness" that was previously displayed when the client was confronted with uncertainty. A complex alternative set of hypotheses could be derived if we consider medical causes. Could the enuresis be a function of the sudden onset of diabetes, which is often accompanied by increased urinary frequency? Neurological complicity is also possible, i.e., normal pressure hydrocephalus. Finally, we must also consider other factors ever present when serving neuropsychiatric populations, the side effects of medication. This example sets the stage for the next principle of functional assessment.

Functional assessment must be comprehensive. It could be argued that this principle relates not only to the breadth and scope of the assessment methodology, per se, but also the overall status of the client; that is, his or her physical, emotional, social and cognitive status. The above example highlights the fact that functional assessment does not occur in a vacuum. The active consideration of other assessment data accrued through multidisciplinary means is essential before embarking upon treatment.

This principle has other important implications. Any efforts at functional assessment result in the development of a descriptive data base. This data base allows for the construction of short term and intermediate range goals which are built sequentially into more general long term goals, which in turn lead to a final primary objective. Such sequential planning is frequently facilitated by organizing the items in a functional assessment inventory into developmental sequences that reflect the order of attainment of more complex behaviors.

Developing a comprehensive functional assessment methodology also means it is necessary to go beyond the assessment of pragmatic physical skills, i.e., meal preparation, grooming, or handling public transportation. Behaviors must be cast in light of the emotional and intellectual status of the client because problems in this sphere can significantly negatively influence skill acquisition. Any identified information processing deficits must be considered when developing both training methodologies, as well as well as strategies that will be utilized to sustain "maintenance" behaviors.

Functional assessment requires active client involvement. The extent to which the client is actively involved in the processes of both assessment and

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treatment planning enhance the probability that he or she will understand "what" will be required and "why." At first glance this may seem obvious. There is, however, a significant issue which relates to persons with long term mental illness and the problem motivation. Indeed, special effort may have to be given to engaging the client in the assessment and planning process. Active incorporation of the client into treatment planning can aid in "empowerment." As clients become attuned to what is required of them and, more importantly, why it is required, the chances for successful rehabilitation increase.

Functional assessment should focus on strengths as well as deficits. The ultimate objective is to delineate what the client can as well as cannot do. Often, assessment personnel can slip into a tendency to overfocus on the identification of skill deficits. Functional deficits frequently noted in persons with chronic mental illness include the following (McCue, Unpublished manuscript):

- impairment of abstract attitude and concrete thinking
- inability to make generalizations
- misinterpretations of spoken, written language
- failure to attend
- lack of motivation
- failure to persist in tasks
- inability to get along with others
- lack of initiative
- psychomotor abnormalities
- disturbance of memory and learning
- slow to process information
- difficulties in categorizing and organizing input

An important aspect of rehabilitation interventions, however, is the identification of areas of residual strength. Frequently it is upon these areas that the therapeutic interventions are structured in order to "remediate" or "compensate" for such deficits. It is also important to note that persons with long term mental illness often readily develop a negative self-focus. Anticipation of failure can be a significant stumbling block. The identification of residual strengths can become an important source of therapeutic benefit for certain clients. The development of an improved self-image through this process then influences more positive motivation toward program goals.

Functional assessment requires that the client and the evaluator understand both present and anticipated needs. Rehabilitation effort is understood as a "process" that is ongoing. Evaluation must be conceptualized in the same context. The practitioner must assume the perspective: "Where is my client currently?" Where does he or she need to be in the immediate and long term future?" As indicated previously, it is critical that efforts be directed toward a superordinate goal. Assessment and subsequent intervention strategies provide the bridges to span the gaps between the client's current status and intended outcomes. The process runs smoothly to the degree that both the client and practitioner agree upon realistic goals and methods. Comprehensive functional assessment provides a valid basis for decision making regarding intermediate goals which build logically toward more extended goals.

Conceived in this fashion, functional assessment as a methodology offers an approach to the central question confronted by service providers: "How may I help my clients who have chronic impairments to achieve maximum quality of life and independence in daily activities?"

At its simplest, functional assessment represents a means to describe abilities. Our goal as service and treatment providers is to develop a performance oriented data base or profile of our clients. From this profile, problems and needs are mutually identified, interventions are planned, and long term goals are developed. Periodic re-evaluation across these performance measures provides the means to quantitatively ascertain progress toward the attainment of long term goals. In effect, functional assessment data provide a relevant foundation for many types of case management and treatment related services. If one adopts recommendations described above for conducting any type of functional assessment, that is, behaviorally defining skills and needs in terms that are observable and measurable and following the "rule of the five W's", one has the groundwork available for the ready translation of raw data into prescriptive treatment plans.

It is emphasized that functional assessment remains only one spoke in a more intricate wheel. Each client presents with unique physical and biological endowments, cognitive strengths and weaknesses, affective characteristics, and interpersonal skills. The failure to assess instrumental community-based adult daily (ADL) skills or vocational skills against the backdrop of the aforementioned variables can lead to complications. Attempts at treatment intervention or service implementation should occur only after a comprehensive evaluation is complete. Further, the most successful rehabilitation strategies are presumed to be those which are built upon the client's existing skills, talents and resources.

SPECIAL FUNCTIONAL IMPAIRMENT IN POPULATIONS WITH CHRONIC MENTAL ILLNESS

The development of knowledge about how psychopathology is uniquely manifest across various syndromes is one function of the DSM-III-R classification system. We must, however, look beyond mere description and further examine how various symptom constellations might have an impact upon daily functioning. Symptoms themselves can represent significant impediments to adaptive functioning. The psychoses will be evaluated for their potential impact upon performance. Delusions, hallucinations, and fantasies interfere with perfor-

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mance by blocking or diverting attention from reality demands. Autistic preoccupation significantly interferes with the ability to attend to or respond to interpersonal cues from the world at large These symptoms are the most obvious, florid, and immediately disabling. They are, however the symptoms which respond most immediately to neuroleptic medication.

There are a number of more residual, secondary symptoms which may be manifest even in the face of well controlled Schneiderian first-rank symptoms. Social isolation can reflect itself in anxiety or in severe interpersonal discomfort in social situations. Diminished attention to grooming and hygiene or the improper modulation of behavior in public may negatively influence social acceptance. Oddities in speech and mannerisms might further exacerbate this rejection. Suspiciousness associated with paranoid ideation can radically affect factors such as response to constructive criticism. Subtle thought disorganization and impaired judgment and reasoning can negatively influence complex problem solving. The person who mediates the environment successfully possesses the ability to interpret social cues and react within the boundaries of normal social convention. It can easily be seen, therefore, that psychotic symptoms alone or in combination can seriously interfere with adaptive functioning, especially social adaptation.

We can also associate functional limitations with the symptoms accompanying the affective disorders. Depression, for example, conveys impressions of dysphoric mood and diminished performance ability. Clients vary significantly in the degree to which neurovegetative (sleep, appetite and arousal state) symptoms are manifest. Fatigue and decreased energy can radically affect performance level on the job or in educational arenas. These symptoms may dissipate or they may remain chronically refractory in some patients, thus, imposing long term repercussions. Both "cognitive," as well as the affective repercussions of depressive disorders are now recognized. Severe impairment in occupational efficiency, memory and concentration, and practical problem solving can occur and be more functionally debilitating in the workplace than the mood disturbance.

We have only briefly highlighted some of the "functional" ramifications of symptoms in order to emphasize the need to assess their impact upon a client's "everyday functioning." It is relevant to take the individual symptomatology associated with any DSM-III-R major psychiatric disorder and attempt to conceive of its impact upon motor, cognitive, language, social or executive functions. The breakdown of symptom related problems into subsets is one means of further understanding their specific impact and then individualizing potential intervention or compensatory strategies. There is a further advantage of maintaining a symptom related focus while conducting functional assessments. Once symptoms and problems are clearly defined with this population, it is important to identify the factors which maintain them. Here the emphasis is upon etiological underpinnings of problematic behavior from a biopsychosocial perspective. Treatment efforts should follow as a function of identification of casual determinants. Psychological factors related to genetic, metabolic, and physical abnormalities require primarily pharmacological models of intervention. To the degree that psychosocial factors may influence the course of a disorder (onset, exacerbation, relapse and chronicity), behavioral and social interventions will be appropriate. In this case the practitioner would focus specifically on the antecedent and consequent events that maintain problematic behavior. Frequently, it is a combination of both treatment strategies that is required.

Behavioral Assessment Strategies

Environmental factors must be specifically examined to assess their potential influence on behavior. The practitioner engages in intensive analysis of the factors that support and maintain problematic behavior . Many resources are available which describe the principles of applied behavioral analysis. This discussion touches briefly on only four important components of the process: an understanding of the **Setting** in which the behavior takes place, its **Frequency** or **Duration**, and the **Antecedent** as well as the **Consequent** influences on a particular behavior or set of behaviors.

Setting. The first of the Cohen and Anthony (1984) functional assessment principles discussed focused on the need for environmental specificity. A critical question to be answered is, "In what situations does problematic behavior occur?". In the home?...At work?...In public places?...In isolation? One attempts to establish how generalized or situationally specific the problematic behavior may be. This indicates how complex and focused the resources associated with intervention must be. For example, with a client served in two treatment settings, will the strategies utilized in a partial hospitalization program be the same as those applied in a residential treatment program?

Frequency. It is important to ascertain the frequency or intensity of problematic behaviors. Not only are we interested in how frequently problematic behavior occurs, but also in its relative severity. A low frequency, severe behavior problem such as self-abuse occurring once or twice a week would be considered more critical for intervention than a high frequency obsessive-compulsive behavior problem that is quite innocuous, such as hand wringing.

Antecedent influences. One next focuses on antecedent conditions. What led up to the behavior in question? Antecedent events are rich and complex in their presentations and cover a number of spheres beyond the "behavioral". These include biological determinants such as amount of sleep or affective and situational factors. Any one or a combination of these factors could trigger problematic behavior. The practitioner's role is to delineate isolated (infrequent) antecedent events for those which are encountered more frequently and tend, therefore, to sustain problematic behaviors.

Consequences. The consequences of a behavior affects frequency, duration, and intensity. Consequences tend to strengthen, weaken or extinguish problematic behavior. The "art" of applied behavioral intervention centers on the ability to grasp the nuances of the reinforcement hierarchies and motivational needs that shape behavior. Simply defined, reinforcers are environmental consequences which increase the probability that a preceding behavior will occur or be learned in the future. In populations of persons with chronic psychiatric disabilities, an important function is one of propagating a set of new, socially appropriate reinforcers to help sustain desired behaviors.

Behavioral Excesses, Deficits and Assets

The nature of the psychiatric problems clients with severe, chronic disabilities face has the potential to result in the identification of a wide variety of "deficits". The practitioner is also faced with numerous variables which have the potential to positively or negatively impact behavior within a particular program. One means of dealing with this potential "information overload" is to reframe behavior in the context of excesses, deficits, and assets. In this fashion, the most problematic negative behaviors are identified (the deficits and excesses), while at the same time the focus of client is also directed toward his or her assets. The assets represent islands of intact skills or abilities..."building blocks." By "keying" on assets, adaptive behavior can be strengthened and problematic behavior displaced or reduced in frequency.

Behavioral excesses represent maladaptive behaviors that occur at rates or intensities so high that they interfere with normal adaptive functioning. Handwashing, a routine activity, becomes pathogonomic in the patient with obsessive-compulsive disorder when it occurs 50 times a day. Behavioral deficits represent necessary behaviors that occur with insufficient frequency, inadequate intensity, or in an inappropriate form. The "negative symptoms" of clients diagnosed with one form of chronic schizophrenia are representative of this class of deficits. Behavioral assets include social competencies, coping efforts, skills interests and abilities of the client, as well as his or her available social supports.

Moving beyond the mere identification of "strengths and needs" requires the capacity to translate outcome goals into specific behavioral categories that will become the object of treatment interventions. This is readily conveyed in the following example. A middle-aged male with a chronic history of refractory schizophrenic symptomology is discharged from a hospital to your care. He presents with very good social-conversational skills. His delusions, however, remain quite chronic. He becomes self-absorbed with content, particularly when he is alone or idle. He spends greater than 70% of every idle hour engaged in "self-talk". However, reduced rates of documented delusional references are reported when he is otherwise engaged in social activities. When information is reported and structured in this fashion, it becomes readily apparent what strategies might immediately be considered regarding intervention.

We will address one further point in this regard--the need to persistently refocus our ongoing assessments on the identification of client assets. A pitfall for the professional working with seriously compromised clients is a tendency to slip into a cognitive set in which the focus is primarily upon the analysis of client deficits. Therefore, in conducting functional assessments it is valuable to develop an "inventory of assets." There is a need to go beyond the simple listing of strengths as might be ascertained from an analysis of adaptive behavior rating scale results. This inventory should include an analysis of supplemental information that can be derived from interviews, accrual of client records and retrospective review of history, all of which help make this information more situationally relevant. The following questions can be used to organize this information:

1. What are the areas in which the client has consistently functioned best now and in the immediate past?
2. What does the client view as his or her most significant asset?
3. What is the extent of his or her available resources in terms of interpersonal and social supports?
4. What agencies and helping professionals are available to be mobilized in his or her behalf? With whom are there established favorable relationships?
5. What personal motivations and incentive to change have been identified?
6. What are the positive aspects of my therapeutic alliance with this client?

When staff move beyond the simple listing of "assets" to considering their implications in terms of "systems related issues" that are pertinent to the client's support, a foundation is laid for the transfer of this information into viable recommendations for service provision or treatment planning.

The Nested Skills Approach to Assessment and Training

One final strategy to be incorporated in the methodologies of functional assessment will be discussed. Critical in the rehabilitation of the individual with long term chronic disability is the question of whether or not the client can be trained to carry out routines of behavior. Daily living experiences are not limited to the carrying-out of discrete, isolated behaviors. Rather, our daily behavior reflects intricate routines and sub-routines organized in a complex interdependent fashion. Groups of actions are organized to meet the environmental demands with which we are confronted. Up to now we have only spoken of functional assessment and intervention strategies occurring in a dichotomous fashion: "Are they present or absent?"..."How frequently do they occur?" A more critical question centers on the ability of the client to carry-out complex multi-step operations and integrated actions. How effective is he or she in adapting behavior in the face of conflicting or changing environmental demands? How complex a routine is he or she capable of carrying out? In order to address these issues, data from the neuropsychological evaluation of executive functions take on special importance.

An example taken from the assessment of self-care skills associated with early morning routines will be considered. Typically, we would assess component skills associated with the discrete activities involved i.e., toileting, washing, shaving, toothbrushing, grooming, dressing. When we consider human behavior, we quickly realize how we rely upon "routines" in conducting such activities. It is frequently the case that when clients are screened across these behaviors, it is determined they are fully competent when performing each isolated activity. Missing in this limited analysis, however, is the evaluation of the degree to which the client can self-initiate and self-monitor sequences of these activities. Specifically, is the client self-motivated to perform these sequences of activities daily? Are there breakdowns in the sequences such that day-to-day they are completed in "hit or miss" fashion? Are some behaviors initiated appropriately but haphazardly carried out? Clients facing the consequences of long term, chronic mental illness typically have not lost the basic skills in conducting such activities, but may have instead developed deficiencies in the "executive functions" which relate to planning, organizing, or maintaining such activities. Although this is perhaps an overly simplistic example, one can extend the analogy to some of the complex behavioral expectancies staff impose upon clients. We must be mindful of breaking our assessment and training strategies into formats that permit a determination of how well the client can proceed through multi-step and sequential operations. Critical in this regard is the question, "Can the client consistently maintain these sequences? In a number of instances it may be found that we do not have to engage the client in skill acquisition training. Rather, what may be required is a refocus on the development of strategies that will aid clients in more effectively utilizing the self-monitoring, judgement, and reasoning skills needed to maintain and adapt their daily behavioral routines.

Resource Management

Once the functional assessment has been conducted and goals identified, resources must be inventoried and organized before proceeding with the rehabilitation plan. The client and counselor must actively consider the required resources which will have to be brought to bear in program implementation. This relates to multiple factors such as time, money, agencies, facilities, or transportation. There will need to be a delineation of who will assume the responsibility to carry-out individual aspects of the plan. A comprehensive assessment of the client's capacity to carry-out complex behaviors as highlighted above should aid greatly in determining the degree to which support will have to be extended in various areas. This support, in turn, will facilitate the client's maximum participation in the rehabilitation process.

SUMMARY

An overview of principles associated with both traditional psychometric and functional assessment has been provided. An attempt was made to highlight a variety of methodologies available toward this end. Within this context, special considerations were discussed which relate to the assessment of social, cognitive, and adaptational limitations of clients with severe and chronic psychiatric disabilities. Functional assessment was addressed as both a philosophy or orientation and as a technique. Thus, even traditional psychometric assessment methodologies if interpreted in the context of everyday problem solving skills can take on greater relevancy in client description. In a truly comprehensive approach toward assessment, adoption of a functional approach toward testing provides a definition of the client's 1) information processing style, 2) cognitive strengths and deficits, 3) problem solving skills, 4) coping resources, 5) personality style, and 6) strengths and weaknesses in environmentally specific skills that pertain to his or her residential, employment, and social living circumstances.

Functional assessment represents more than the mechanistic application of structured behavioral assessment strategies for the purposes of problem formulation. Rather, it represents a philosophy which can be adapted toward any of the more traditional forms of medical, psychological, and social casework assessment strategies as well. Indeed, this philosophy can be adapted to any evaluation which attempts to contribute to the understanding of how the quality of life and independence of a client with chronic mental illness can be furthered.

Special emphasis in this discussion has also focused on applications of neuropsychological evaluation techniques. Yozawitz (1986) and Erickson & Binder (1986) have taken the notion of competency based neuropsychological profiles and have applied them in the context of rehabilitation programming. Liberman, et al, (1986) summarize approaches to both social skill and social problem solving training focused on the unique information processing capacities (attentional and cognitive) of clients that could influence performance.

Thus, it would appear that we have available technologies which have the potential to further enhance rehabilitation outcome through the enhanced description of client ability structure. The future requires the development of paradigms that will assess the efficacy of such enhanced descriptions of client ability.

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CHAPTER 7

ACHIEVEMENT TESTING

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INTRODUCTION

During the mid-1970s the use of standardized tests among a variety of elementary, secondary, and post-secondary educational programs came under severe criticism. It had been reported that the use of standardized achievement tests in particular involved over 80% of American school children, with some of these children taking 26 achievement tests during a school career (National School Boards Association, 1977). It has been postulated that this national concern with standardized tests has resulted from competition among the "baby boom" generation children of the late 1940s and early 1950s for "scarce slots in the choicest schools and businesses," so that their stakes of doing well or poorly on tests went up. Second, those same baby boomers were looking back on their experiences with years of taking standardized tests and were very sensitive to the perceived abuses of such testing (Strenio, 1981, p. xviii). The main criticisms of these tests have centered around the quality of the tests themselves, the use to which they are put, the behavior of the test industry (some 40 to 50 test publishers responsible for 90% of the tests used in the country today), and the consequences for society of the misuse of these tests. In addition, major court cases and federal legislation for exceptional children have addressed specifically the use of tests and testing as part of the overall assessment process (*Larry P. v. Riles* and P.L. 94-142), again in response to these same criticisms.

In November, 1975, at a conference on testing sponsored by the National Association of Elementary School Principals and the North Dakota Study Group on Evaluation, 25 national organizations including the U.S. Office of Education drafted the following statement:

> We believe that the public, and especially educators, parents, and children, need fair and effective assessment processes that can be used for diagnosing and prescribing for the needs of individual children.
>
> We also believe that the use of fair, effective assessment practices is one way of being held accountable for providing quality education for all students.
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> We have grave reservations, however, about any continued use of so-called IQ tests.
>
> In regard to standardized achievement tests, we have agreed on the following recommendations:
>
> 1. The profession needs to place a high priority on developing and putting into wide use new processes of assessment that are more fair and effective than those currently in use and that more adequately consider the diverse talents, abilities, and cultural backgrounds of children.
> 2. Parents and educators need to be much more actively involved in the planning and processes of assessment.
> 3. Any assessment results reported to the public must include explanatory material that details the limitations inherent in the assessment instruments used.
> 4. Educational achievement must be reported in terms broader than single-score national norms, which can be misleading.
> 5. Information about assessment processes should be shared among the relevant professions, policy makers, and the public so that appropriate improvements and reforms can be discussed by all parties.
> 6. Every standardized test administered to a child should be returned to the school for analysis by the teachers, parents, and child.

Table 7.1. Commonly Used Achievement Tests

Group Administered Achievement Tests	
California Achievement Tests	CTB/McGraw Hill. (1984). California Achievement Tests. Monterey, CA: Author.
Iowa Test of Basic Skills	Hieronymus, E. F., Lindquist, H. D., Hoover, D., et al. (1978). Iowa Test of Basic Skills. Chicago, IL: Riverside Publishing.
Metropolitan Achievement Tests	Balow, I. H., Farr, R., Hogan, T. P., Prescott, G. A. (1978). Metropolitan Achievement Tests (5th ed.). Cleveland, OH: Psychological Corporation.
Stanford Achievement Test	Gardner, E. G., Rudman, H. C., Karlson, B., & Merwin, J. C. (1982). Stanford Achievement Test. Cleveland, OH: Psychological Corporation.
SRA Achievement Services (SRA)	Naslond, R. A., Thorpe, L. P., & Lefever, D. W. (1978). SRA Achievement Series, Chicago, IL: Science Research Associates.
Individually Administered Achievement Tests	
Basic Achievement Skills Individual Screener (BASIS)	Psychological Corporation. (1983). Basic Achievement Skills Individual Screener. San Antonio: Author.
Kaufman Test of Educational Achievement	Kaufman, A. S., & Kaufman, N. G. (1985). Kaufman Test of Individual Achievement. Circle Pines, MN: American Guidance Service.
Peabody Individual Achievement Test—Revised	Markwarat, F. C. (1989). Peabody Individual Achievement Test. Circle Pines, MN: American Guidance Service.
Wide Range Achievement Test	Jastak, S., & Wilkinson, G. S. (1984). Wide Range Achievement Test—Revised. Wilmington, DE: Jastak Associates.
Woodcock Johnson Psychoeducational Battery	Woodcock, R. W. (1977). Woodcock Johnson Psychoeducational Battery: Technical Report. Allen, TX: DLM Teaching Resources.
Modality Specific Achievement Tests	
Reading	
Classroom Reading Inventory	Silvaroli, N. J. (1986). Classroom Reading Inventory (5th ed.). Dubuque, IA: Wm. C. Brown.
Diagnostic Reading Scales	Spache, G. D. (1981). Diagnostic Reading Scales. Monterey, CA: CTB/McGraw-Hill.
Durrell Analysis of Reading Difficulty	Durrell, D. D., & Catterson, J. H. (1980). Durrell Analysis of Reading Difficulty (3rd ed.). Cleveland, OH: Psychological Corporation.
New Sucher-Allred Reading Placement Survey	Sucher, F., & Allred, R. A. (1981). New Sucher-Allred Reading Placement Inventory. Oklahoma City: Economy Company.
Gates-MacGinitie Reading Tests	MacGinitie, W. H., et al. (1978). Gates-MacGinitie Reading Tests. Chicago, IL: Riverside Publishing.
Nelson-Denny Reading Test	Brown, J. I., Bennett, M., & Hanna, G. (1981). Nelson-Denny Reading Test. Chicago, IL: Riverside Publishing Co.
Stanford Diagnostic Reading Test	Karlson B., Madden, R., & Gardner, E. F. (1976). Stanford Diagnostic Reading Test (1976 ed.). Cleveland, OH: Psychological Corporation.
Mathematics	
Enright Diagnostic Inventory of Basic Arithmetic Skills	Enright, F. E. (1983). Enright Diagnostic Inventory of Basic Arithmetic Skills. North Billerica, MA: Curriculum Associates.

7. Further, the standardized tests used in any given community should be made publicly available to that community to give citizens an opportunity to understand and review the tests in use.
8. The professions, the public, and the media need to give far greater consideration to the impact of standardized testing on children and young people, particularly on those below the age of ten.
9. A comprehensive study should be conducted on the actual administration and use of standardized tests and the use of test scores in the schools today. (National School Boards Association, 1977, p. 18)

Thus, it is relevant and timely more than a decade later to

- review the historical development, classification, and psychometric properties of traditional achievement tests;
- update their status and use in terms of contemporary educational and clinical research and practice;
- consider the relationship of achievement testing to ecological and sociocultural variables and their use with special population groups; and
- take a futuristic look at the impact of modern computer technology on test construction and utilization.

Such a discussion may determine whether these recommendations regarding the use of achievement tests long since made, have been or will need to continue to be addressed.

Historical Development of Achievement Tests

The standardized objective achievement test based upon a normative sample was first developed by Rice in 1895. His spelling test of 50 words (with alternate forms) was administered to 16,000 students in grades 4 through 8 across the country. Rice went on to develop tests in arithmetic and language, but his major contribution was his objective and scientific approach to the assessment of student knowledge (DuBois, 1970). Numerous other single-subject-matter achievement tests were developed in the first decade of the twentieth century, but it was not until the early 1920s that the publication of test batteries emerged: in 1923, the Stanford Achievement Test at the elementary level, and in 1925, the Iowa High School Content Examination (Mehrens & Lehmann, 1975). Since the 1940s, there has been a movement toward testing in broad areas as well, such as the humanities and natural sciences rather than in specialized, single-subject-matter tests. Moreover, attention has been directed toward the evaluation of work-study skills, comprehension, and understanding, rather than factual recall per se. In the 1970s, standardized tests were developed that were keyed to particular test books, the use of "criterion-referenced" tests (CRTs) emerged (their dissimilarity from norm-referenced tests will be addressed in the next section), and the development of "tailored-to-user specifications" tests (Mehrens & Lehmann, 1975, p. 165) was initiated.

Now in the 1990s, the literature on achievement testing is concerned with latent-trait theory, item-response curves, and an assessment of learning achievement that is brief into the instructional process. The intrinsic nature of achievement tests themselves is changing. Computer-adaptive testing is not the computerization of standardized norm-referenced paper-and-pencil tests but a radically different approach. The approach is based on a concept of a continuum of learning and where a particular child fits on that continuum so that his or her experience with testing is one of success rather than failure. To appreciate fully this dramatic shift in the conceptualization of the assessment of achievement it is first necessary to understand (a) the nature of tests which fall under the domain of achievement; (b) the psychometric underpinnings of achievement tests; (c) the basis for criterion-referenced as opposed to norm-referenced measurement; and (d) particular issues which arise when achievement tests are used for particular purposes.

Classification of Achievement Tests

Achievement tests have generally been categorized as single-subject tests, survey batteries, or diagnostic tests and further dichotomized as group or individually administered tests. Reference to the *Ninth Mental Measurement Yearbook* (1985) reveals the prevalence of multitudinous published objective tests, and elsewhere it has been reported that some 2,585 standardized tests are in use (Buros, 1974). Table 7.1 is a listing of the most commonly used achievement tests. They have been categorized as (a) group administered, (b) individually administered, and (c) modality specific tests of achievements, which can be either group or individually administered.

Typically one administers achievement tests in order to obtain an indication of general academic skill competencies or a greater understanding of an individual's performance in a particular area of academic performance. In this regard achievement tests are specifically designed to measure "degree of learning"

Table 7.1. Commonly Used Achievement Tests (*Continued*)

Modality Specific Achievement Tests (*Continued*)

Keymath Diagnostic Arithmetic Test	Connolly, A. J., Nachtmam, W., & Pritchett, E. M. (1971). The Keymath Diagnostic Arithmetic Test. Circle Pines, MN: American Guidance Service.
Sequential Assessment of Mathematics Inventories	Reisman, F. K. (1985). Sequential Assessment of Mathematics Inventories. San Antonio, TX: Psychological Corporation.
Stanford Diagnostic Mathematics Test	Beatty, L. S., Madden, R., Gardner, E. G., Karlsen, B. (1976). Stanford Diagnostic Mathematics Test. Cleveland, OH: Psychological Corporation.

in specific content areas. There are several distinct applications of achievement tests which vary as a function of the setting in which they are applied. Tests such as the Metropolitan Achievement Tests, Stanford Achievement Tests, California Achievement Tests, and Iowa Tests of Basic Skills represent instruments which typically consist of test category content in six or more skill areas. The benefit of the battery approach is that it permits comparison of individual performances across diverse subjects. Because all the content areas are standardized on the same population, differences in level of performance among skill areas can reflect areas of particular strength or deficit. Many of these instruments provide a profile as well as a composite score that allows ready comparison of levels of performance between tests. The representative content of these batteries typically includes core assessment of language, reading, and mathematics abilities. The extensiveness of the coverage of allied curricula, that is, science, humanities, and social studies, varies significantly. Sax (1974) provides a description of the major differentiating characteristics of 10 of the most commonly used achievement test batteries.

In contrast to the "survey" type tests or screening batteries described above are the more content focused diagnostic achievement tests. Although any of the survey instruments is available to identify areas of academic strength or weakness (Radencich, 1985), they are not in themselves sufficient for diagnostic or remediation planning purposes. Their use in screening large groups helps to identify those individuals in need of more specific individualized diagnostic evaluation. Through the use of a diagnostic battery an area of identified deficit is examined in a more extensive fashion to determine what factors contribute to the academic dysfunction. Typically, these tests include a broad enough sampling of material so that areas of need are specified in order to develop remedial instructional objectives. For example, the Woodcock Reading Mastery Test (Woodcock, 1973) provides five subtests which examine component processes associated with overall reading ability. These include Letter Recognition, Word Attack, Word Recognition, Word Comprehension, and Passage Comprehension. More in-depth examination at this level permits hypothesis generation regarding the nature of the specific academic deficit to be further tested. Similar tests are available to assess other aspects of academic performance: mathematics, spelling, writing, language skills, etc. Refined assessment at this level is necessary for differential diagnosis and remedial intervention. Screening batteries simply do not permit sufficient evaluation of an area for this kind of decision making to take place.

Although most achievement tests have the potential to be used as screening instruments to identify individuals in need of remedial instruction, fewer instruments are actually used for diagnostic purposes. In a national survey, Goh, Teslow, and Fuller (1981) reported that the Wide Range Achievement Test and the Peabody Individual Achievement served as the general achievement batteries most commonly utilized by school psychologists. In the area of specific achievement tests, the Key Math Diagnostic Achievement Test, Illinois Test of Psycholinguistic Abilities, and Woodcock Reading Mastery Tests ranked as the instruments used most frequently for the assessment of specific academic content areas.

Criterion-Referenced versus Norm-Referenced Achievement Tests

One other highly significant dichotomy must be addressed when discussing the classification of achievement tests and certain of their psychometric properties, namely, the distinction between criterion-referenced tests (CRTs) and norm-referenced tests (NRTs). While it is not possible to differentiate one from the other in terms of visual inspection (a criterion-referenced test can also be used as a norm-referenced test: for example, Basic Achievement Skills Individual Screener), there are intrinsic differences between the two approaches to achievement testing. Traub and Rowley (1980) described the decade of the 1970s as a time when "the notion of criterion-referenced measurement captured and held the attention of the measurement profession unlike any other idea" (p. 517). Mehrens and Lehmann (1975) asserted that the issues of accountability, performance contracting, formative evaluation, computer-assisted instruction, individually prescribed instruction, and mastery learning created a need for a new kind of test, the criterion-referenced test.

The concept of criterion-referenced achievement measurement was first detailed in the 1963 paper by Robert Glaser entitled "Instructional Technology and the Measurement of Learning Outcomes: Some Questions." In that landmark publication Glaser wrote:

> Underlying the concept of achievement is the notion of a continuum of knowledge acquisition ranging from no proficiency at all to perfect performance. An individual's achievement level falls at some point on this continuum as indicated by behaviors he displays during testing. The degree to which his achievement resembles desired performance at any specified level is assessed by criterion-referenced measures of achievement or proficiency. . . . Criterion levels can be established at any point in instruction. . . .
>
> Criterion-referenced measures indicate the content of the behavioral repertory. . . . Measures which assess student achievement in terms of a criterion standard . . . provide information as to the degree of competence attained by a particular student which is independent of reference to the performance of others. (p. 519).

Glaser further stated that achievement measures are appropriately used to provide information regarding a student's capability in relation to the capabilities of his or her fellow students as well. Where an individual's relative standing along the continuum of attainment is the primary concern, the appropriate achievement measure is one that is norm referenced. Whereas both CRTs and NRTs are used to make decisions about individuals, NRTs are usually employed where a degree of selectivity is required by a situation, as opposed to situations in which concern is only with whether an individual possesses a particular competence and there are no constraints regarding how many individuals possess that skill. Thus, at the core of the difference between the two kinds of tests is the issue of variability. "Since the meaningfulness of a norm-referenced score is basically dependent on the relative position of the score in comparison with other scores, the more variability in the scores the better" (Popham, 1971). This obviously is not a requirement of the criterion-referenced measure.

Because of basic differences in the theories underlying test construction, there have been several hundred publications on CRTs dealing with such issues as test reliability, determination of test length (Millman, 1973), score variability (Hambleton & Cignor, 1978; Hambleton, 1980), and test validity (Linn, 1982). The psychometric properties of CRTs have undergone close scrutiny and one of the most critical dimensions reviewed has been the issue of validity. In the words of Linn (1980):

> Possibly the greatest short-coming of criterion-referenced measurement is the relative lack of attention that is given to questions of validity of the measures. The clear definitions of content domains and well-specified procedures for item generation of some of the better criterion-referenced measures places the content validity of the tests on much firmer ground than has been typical of other types of achievement tests. Content validity provides an excellent foundations for a criterion-referenced test; but . . . more is needed to support the validity of inferences and uses of criterion-referenced tests. Unfortunately, the accumulation and reporting of evidence to support the uses and interpretations of criterion-referenced tests is the exception rather than the rule.
>
> In their review of 12 commercially prepared criterion-referenced tests, Hambleton and Eignor (1978) did not find a single one that had a test manual that included satisfactory evidence of validity (Hambleton, 1980). Validity has too often been assumed by both developers and users of criterion-referenced tests. This is no more acceptable for a criterion-referenced test than it is for any other test. It is time that questions of validity of the uses and interpretations of criterion-referenced tests be given the attention they deserve. (p. 559)

Despite these criticisms from the point of view of traditional test construction theory, criterion-referenced measurement has been found to have major utility with respect to the development of computer-assisted, computer-managed, and self-paced instructional systems. In all of these instructional systems, testing is closely allied with the instructional process, being introduced before, during, and after the completion of particular learning units as a monitoring, diagnostic, and prescriptive mechanism (Anastasi, 1982). Moreover, it has had practical application with respect to concerns with minimum competency testing (Hunter & Burke, 1987; Lazarus, 1981) and mastery testing (Harnisch, 1985; Kingsbury & Weiss, 1979).

Curriculum-Based Measurement

In addition to criterion-referenced and norm-referenced tests of achievement, one additional "hybrid"—which appears to be surfacing, particularly in the area of special education—*curriculum-based measurement* (CBM), merits a brief note in this review. From the Institute for Research on Learning Disabilities at the University of Minnesota, Deno (1985) and his colleagues have proposed a method of measurement which lies somewhere between the use of commercialized tests and informal teacher observations. Their initial research with the procedure in the areas of reading, spelling, and written expression, and concerns with reliability, validity, and limitations are reviewed by Deno. Among the limitations are its utility only with the domain of reading at present, its lack of stability estimates as indicative of reliability, and its lack of generality that enables aggregation across curricula.

However, one aspect of CBM that appears to mark a distinct embarkation from traditional achievement testing is the concept of frequent measurement. In addition to the work of Mirkin, Deno, Tindal, and Kuehnle (1982) on the measurement of spelling achievement with learning disabled students, Le Mahieu (1984) has reported on the extensive use of a program of frequent assessment known as the Monitoring Achievement in Pittsburgh (MAP) which began in 1980 and involves 81 schools with a total enrollment of 40,000 students. Students are tested every six weeks with curriculum-based measures developed by committees of teachers. Serious risks in this kind of achievement testing involve the potential for teachers to narrow the curriculum and to teach to the assessment instrument as well as for students themselves to develop and refine test-wise behaviors as opposed to attaining specific academic skills.

USE OF ACHIEVEMENT TESTS

Achievement Tests in Education

Within the context of educational programs there is a continual process of evaluation which also includes teacher-made tests and letter-grade performance standards. The continuous monitoring of student performance within a particular academic content area provides means not only to assess student progress but also to link instructional strategies and learning objectives with identified student learning needs and/or skill deficits. The periodic administration of achievement tests has traditionally been viewed as an educationally sound procedure by professionals in the field despite criticisms with respect to the misuse or inappropriate use of these tests.

From a positive perspective, Anastasi (1988) provides a summary of their usefulness in educational settings. First, their inherent objectivity and uniformity provide an important tool in assessing the significance of grades. While individual classroom performance measures can be susceptible to fluctuation due to a number of variables, their correlation with achievement test scores provides a useful comparative validity criterion for grades. They are especially useful in the identification of students whose limited progress in a content area will require remedial intervention. Within this context, individualization of specific needs can be identified so that individual and group curricula can be modified. In this regard, the use of achievement tests prior to the initiation of training can become particularly efficacious. When these measures are utilized at the end of an instructional period they have the potential to serve as a means for assessing the quality of instructional programming and aiding in programmatic evaluation.

In general, then, achievement tests are used to make decisions, decisions which may involve instructional, guidance, or administrative issues. For example, what is the efficacy of a particular method of instruction? What are the specific outcomes of learning? Is there a need for remediation? Are grading practices accurate? Is the curriculum responsive to the acquisition of basic and/or specific academic skills? Is counseling appropriate for any given student? Is appropriate placement a concern? Thus, the breadth of the assessment will be predicated upon the rationale for the use of particular achievement measures. Table 7.2 illustrates the types of questions or problems which may be addressed and the expected benefit(s) to be derived from the testing process.

Achievement versus Aptitude

One further point which any review of achievement tests must certainly address with respect to their classification and use is the notion of aptitude versus achievement. This contrast dates back to the preoccupation of educational psychologists in the 1920s and 1930s with the role of heredity versus environment in the learning arena. This early simplistic notion that innate capacity or potential could be measured by aptitude tests independent of an individual's learning history or "reactional biography" (Anastasi, 1984, p. 363) has been disavowed. Replacing the traditional concepts of aptitude and achievement in psychometrics is the concept of "developed abilities," the level of development attained by an individual in one or more

Table 7.2. Achievement Tests: Purpose and Outcome

PURPOSE OF TESTING	OUTCOME CRITERION
Screening:	Identification of students potentially eligible for remedial programming
Classification/Placement:	Specific academic deficiencies have been ascertained. Question now arises regarding whether student meets eligibility criteria.
Prescriptive Intervention:	A specific developmental arithemtic disorder is manifested in a child identified with visuo-perceptual processing problems. What curriculum adjustments appear warranted?
Program Evaluation:	Administrators seek to evaluate benefits of an accelerated reading program for gifted students

abilities (Anastasi, 1982, p. 395). In line with this conceptualization of the measurement of abilities, Anastasi provides a continuum of testing in terms of the "specificity of experiential background" that particular tests presuppose. The continuum ranges from course-oriented achievement tests to broadly oriented achievement tests to verbal-type intelligence to "culture-fair" tests. This continuum more accurately reflects the overlapping of aptitude and achievement tests. This analysis has been demonstrated empirically over and over in terms of the high correlations between achievement and intelligence tests. "In some instances, in fact, the correlation between achievement and intelligence tests is as high as the reliability coefficients of each test" (Anastasi, 1982, p. 395).

Finally, Anastasi notes that the continued labeling of some tests as aptitude or achievement measures has led to misuses of test results—in particular, the identification of certain children as underachievers when their respective achievement test scores are lower than their scholastic aptitude or intelligence test scores. In the words of Anastasi:

> Actually, such intraindividual differences in test scores reflect the universal fact that no two tests . . . correlate perfectly with each other. . . . Among the reasons for the prediction errors in individual cases are the unreliability of the measuring instruments, differences in content coverage, the varied effects of attitudinal and motivational factors on the two measures, and the impact of such intervening experiences as remedial instruction or a long illness. (p. 396)

Scoring Systems Associated with Tests of Academic Achievement

Before further discussion of the application of achievement test data, it is necessary to consider how the results of these tests are conveyed. Raw scores derived from achievement tests are typically converted to age or grade equivalent scores, standard scores, or percentile scores. Hoover (1984) makes a useful distinction between two scoring dichotomies. *Developmental scores* compare individual performance to that of a series of reference groups that differ systematically and developmentally in average achievement, with developmental scores being expressed as age or grade equivalent scores. *Status scores* compare test performance with a single normative reference group and are expressed as standard scores and percentiles. It is important to distinguish between the two types of measurement as each has unique strengths and limitations.

Developmental Scores

Age Equivalent Scores. Educational Age (EA) represents a scoring criterion which has come under significant criticism and is used very infrequently in reporting educational test data. The scaling of items on some achievement tests is presented in a developmental sequence such that a particular score represents mean level of performance for a specific age reference group. An individual who attains a specific score on the test is reported to function at a particular age level. This system of score reporting is useful for descriptive purposes, especially for "measuring growth." As in grade equivalent scores which will be discussed next, serious flaws are encountered when one attempts to utilize such scores for comparative purposes, however.

Grade Equivalent Scores. A grade equivalent score (GE) reflects the presumed level of performance of an average student at a particular grade level. For example, if the mean score of a group of sixth graders on an achievement test is reported as $\bar{m} = 6.2$, children who attain the same score are imputed to function at a level of performance commensurate with sixth graders in general. Although it is quite important to have available a continuous scale describing developmental level as a means to demonstrate progress in attainment and growth, the GE represents one of the most frequently misinterpreted sources of educational data. First, it should be noted that GE scores are reported in a format that reflects both grade level and month. The typical school year is approximately 10 months. Hence, scores of 6.2 and 6.9 contrast levels of performance commensurate with the beginning and end of the school year. There are, however, limitations on direct interpretation of GE scores. The scaling of achievement test data is rarely a continuous process. Scores for many grade equivalents are frequently extrapolated or interpolated and consequently do not reflect actual derived scores. They are in fact estimations based on a hypothetical grade equivalent curve. The use of such a scale also presumes that the teaching of such skills is a continuous process reflected across grades. This is not, however, reflected in the reality of the educational experience. Gains made by students are more realistically seen as a combination of spurts and plateaus, and not as a continuous process as is mathematically interpolated in scale construction.

The most significant limitation in the use of GE scores appears to arise because they are ordinal measures. The difference between a one-year gain in proficiency at a lower grade level in comparison to that same gain at a higher grade level may be significant. Further, because most of the basic core academic competencies are taught within the first through eighth grades, one cannot presume that grade equivalent scores associated with the terminal stages of the educational career are equivalent. Finally, it must be noted that relatively small differences in performance can result in exaggerated differences in grade-level equivalency owing to the nature of scale construction.

The most frequently cited problem with using GE scores is the potential for misinterpretation of significant differences in level of performance. For example, a fourth grader obtains a score of 6.7 in reading. One cannot directly compare this youngster to other sixth graders. It is an erroneous assumption to state that this child's reading ability is commensurate with that of a sixth grader. His reference group remains fourth graders. He clearly demonstrates well-above-average performance in comparison to this reference group. One cannot, however, compare him to sixth graders who by the nature of their development and experience with reading, are different from our fourth grader. Because of the inherent potential for parents to set inappropriate standards of performance for their children based on such scores, the use of scores has been abandoned in many quarters.

Status Scores

A wide variety of standard score methodologies are available for reporting test results. These represent scores scaled along a continuum which permits one to ascertain where a particular score may fall in comparison to other scores in a distribution. There are two distinct advantages to the utilization of this scoring system. Standard scores permit the opportunity to compare individual performance to a normative standard, and they make possible the comparison of individual performance across two or more different tests. The latter represents an important criterion for the application of achievement tests within the context of a larger test battery.

Percentiles. Percentile rank represents a point in a distribution at or below which the scores of a given percentage of subjects fall. If a student scored at the 95th percentile, this would mean his or her score was better than 95% of the other students who took the same test. When clearly conveyed in the context of a psychological report, this scoring methodology represents one of the most readily understandable forms of test description. The potential for inappropriate comparisons of level of performance as reflected in the GE score example is significantly reduced.

Standard Scores. Standard scores represent raw scores which have been scaled relevant to a constant mean and standard deviation. As a function of the magnitude of the standard deviation, one can through linear transformation readily ascertain how far from the mean performance lies. Most tests standardize scores within defined age groups. Therefore, regardless of the age of the subjects under evaluation, a specific standard score will have the same meaning. For example, if two students, ages 8 and 10, obtain the same standard score on a reading test, relative to the normal curve, one can readily distinguish that in comparison to their age mates, they are functioning at equal distance from the mean. Standard score conversions also include z scores, t scores, and occasionally stanine scores which can be interpreted in like manner. In general, standard scores are considered the more accurate and precise means of reporting test results. Finally, it is not uncommon for test developers to provide multiple methods for performance description. For example, the Wide Range Achievement

Test-Revised provides grade equivalent scores, age-based standard scores, and percentiles.

Achievement Test Scores and the Diagnosis of Learning Disabilities

The relevance of understanding the scoring systems utilized in the interpretation of achievement test results can be dramatically illustrated when one considers the educational diagnosis of a specific learning disability. Learning disabilities have become the dominant handicap of school-age children in the country with some 42% of all students ages 3 to 21 in special education programs diagnosed as learning disabled (Databank, 1985).

A basic assumption underlying learning disabilities is the failure of the student to acquire primary academic skills at levels expected for age, grade placement, and level of intellectual functioning. The identification of individuals with learning disabilities has traditionally been based on the notion of a "significant discrepancy" between ability level and demonstrated academic skill attainment. Regardless of which of the many formulas is used to diagnose a learning disability, all require data from standardized achievement tests. Thus, the use of achievement testing has become an integral component in the differential diagnosis of learning disabilities. In this regard, the concept of "significant discrepancy" has been an important one for it forms the basis for distinguishing specific learning disability diagnoses from conditions such as underachievement or mental retardation.

Under Public Law 94-142, the Education for All Handicapped Children Act of 1975, it was specified that a team could render a determination of specific learning disability if a child does not achieve at his or her ability level when provided with appropriate educational instruction and if a severe discrepancy exists between intellectual ability and achievement in one or more of seven areas of achievement including oral expression, listening comprehension, written expression, basic reading skills, reading comprehension, mathematics calculation, or reasoning. Specifically excluded along with mental retardation were other factors which could impinge on limited academic proficiency, such as peripheral sensory or motor handicaps, emotional disturbance, or socioeconomic or cultural disadvantage. The actual specification of the means of ascertaining discrepant performance is left vague in this definition. Algozzine, Ysseldyke, and Shinn (1982) emphasize that the field of learning disabilities has always suffered a definitional dilemma. Federal guidelines have not appreciably corrected this situation. No clear consensus across school districts exists nationally for arriving at workable definitions of learning disability diagnoses.

In spite of the lack of consensus regarding definition, the notion of severe discrepancy has been defined most frequently by the use of an ability-achievement discrepancy. Inherent in this conceptualization of learning disability is the potential for at least average intellectual functioning with academic performance well below expectations. A number of strategies have been applied in an attempt to operationalize criteria representative of a severe discrepancy.

Deviation from grade level. A commonly encountered criterion to define a potential learning disability might be "grade level performance in academic achievement two grade levels below expectation for age." This criterion has been criticized as inadequate for a number of reasons. First, as previously discussed, grade-level equivalents represent the weakest psychometric criterion upon which to base comparisons of academic performance. Second, utilization of such a constant criterion fails to take into consideration the significance of discrepant performance at various points in the continuum of educational programming. For example, performance two grade levels below expectation in a third grader can be far more significant than the same magnitude of score deficit in an eighth grader. Further, in the assessment of adult populations, the efficacy of grade equivalent scores lose predictive validity. It is extremely difficult to ascertain whether eighth-grade academic skills in a 40-year-old are indicative of any significant disparity in level of performance.

Finally, problems have been identified with potential identification of learning disabled students. Use of grade-level discrepancy criteria tends to overidentify children whose intellectual functioning is low average and to underidentify those students who may be above average. A student with an IQ of 82 might in fact be functioning at a grade level which is not discrepant for his or her overall level of intellectual functioning. On the other hand, a fourth grader who is reading just below grade level, but who has an IQ in the superior range, who should clearly be reading at well above grade level expectations, would be excluded.

Standard Score Discrepancy Models. The process of comparing standard scores derived from academic and intelligence tests holds apparent benefits over grade discrepancy scores on purely psychometric grounds. Typically, a criterion level is arbitrarily selected, a 1 or 2 standard deviation point discrepancy between general ability and achievement test score. This methodology can, however, also impose bias into the discrimination process. Many such models do not take into consideration the regression of IQ on achievement. One cannot assume direct correspondence between IQ and standard score equivalents. It can be demonstrated that academic achievement test scores fall somewhat short of IQ for individuals manifesting above-average performance, and in lower-functioning individuals, academic achievement scores are actually higher. The use of a simple discrepancy score formula implicitly assumes a perfect correlation between general ability and achievement tests which in fact does not exist. It would also require that each test be based on the same standard score distribution.

Regression Equations. The most sophisticated methodologies available for determining significant score discrepancies are based upon complex computations or tables designed from formulas based upon regression equations. A number of strategies have been developed, each with unique distinguishing properties. A number of reviews are available (Forness, Sinclair, & Guthrie, 1983; Reynolds, 1984; Wilson & Reynolds, 1984) which describe the characteristics of these methodologies. There remains, however, no one mathematial model which is commonly accepted or in fact utilized.

Reynolds (1984) reports on the findings of the Work Group on Measurement Issues in the Assessment of Learning Disabilities, a study section formed in 1983. This group was delegated the responsibility of addressing questions directed toward identification of "best practice" solutions to the learning disabilities definitional dilemma. In their findings, models of discrepancy analysis based upon grade-equivalent scores were rejected outright. Factors related to their imprecision and their ready misinterpretation were noted. Most critical, however, was the inherent lack of the mathematical properties necessary for conducting comparative analyses that are associated with this scoring system. The group concluded that age-based standard score discrepancy models represent potentially the best methodology available. However, while developmental standard scores are to be preferred over grade level of status standard scores, their value has been challenged also because they require greater growth for below-average children than for average or above-average children (Clarizio & Phillips, 1986).

One cannot, however, focus exclusively on the concept of discrepancy as the sole basis for the diagnosis of a learning disability. To quote Reynolds (1984), "The establishment of a severe discrepancy is a necessary but insufficient condition for the di of a learning disability" (p. 468). A host of other than specific learning disability can contribute significant academic underachievement. Amo these are limited sociocultural opportunity, dysm vation, sensory-perceptual dysfunction, or functior psychiatric impairment. It is Reynolds' bias, ho ever, that only when a severe discrepancy can demonstrated is a child considered eligible for diagnosis of LD.

Some Thoughts on the Validity Issue

There are, among educators and researchers, th who question the focus on the *reliability* of discrepancy between IQ and achievement rather th on its *validity* (Shepard, 1983). In a study by Shep and Smith (1983), which evaluated the identificati practices of psychologists and teachers within the st of Colorado involving 1,000 student files and 2.0 specialists, 50% of those professionals surveyed we unaware that an IQ of 90 falls at the 25th percenti For children with IQs of 90, the expectation w achievement would be at grade level (the 50th tile) because the IQ was "in the normal range" (She ard, 1983). The authors continued that these speci ists were also unaware that after the first or seco grade it is not uncommon for large numbers of ch dren to have grade-equivalent scores below their gra placement. Other technical problems identified in th study also complicate the identification of LD: Most of the tests used in the diagnosis of LD a technically inadequate with the exception of t WISC-R and one or two achievement batteries; Many clinicians were unaware of the differenc between technically adequate and inadequate tests; Specialists often selected technically inadequate me sures even when more valid instruments were ava able, their choices tending to follow traditional pr erences associated with each professional group; Many clinicians continued to apply inaccurate cc ventional wisdom regarding the symptoms of t disorder (relying on interpretations of subtest scatt underestimating normal patterns of difference, etc.

Reynolds (1984) and the Task Force advanced number of recommendations which attempted bridge this validity-reliability gap with respec diagnosis of LD:

1. Instruments applied should meet criteria defined PL 94-142.
2. Well-standardized national norms should form t

basis for statistical comparison of individual level of performance.

3. Normative comparisons should be based upon co-normed samples. The ideal scenario is one in which the two tests compared are normed on the same sample. Where this is not possible, the two normative groups should be clearly comparable.
4. Only individually administered tests of achievement and intellectual ability should be utilized.
5. Age-based standard scores based upon a common scale represent the most statistically robust means for score comparison.
6. Measures employed should conform to acceptable criteria for validity and reliability.
7. Special technical considerations should be addressed when using performance based measures of achievement (e.g., writing skill).
8. Bias studies should have been conducted and reported.

In summary, while the psychometrics involved in scoring and interpreting the results of achievement tests can be fraught with complexity and controversy, as illustrated in the case of the diagnosis of learning disabilities, the consequences of the resolution of the issues involved are even further reaching. Consider the effects of labeling, the contraction of teacher competence to deal with a variety of learning styles in the classroom, the allocation of resources available to those students with the most severe disability, and the costs of providing for special education resources themselves (Shepard, 1983). All of these can be viewed as negatives. It is not difficult nor unrealistic to extrapolate these same issues to include diverse groups of students in educational programs today. Thus, we are left with ethical responsibilities to insure the appropriate utilization of achievement tests based on the most current thinking and research available which is macrocosmic rather than microcosmic in nature.

Messick (1980) has argued this point in his "Test Validity and the Ethics of Assessment." He had written earlier, with specific reference to the measurement of personality, that tests should be evaluated not only in terms of their measurement properties but also in terms of their potential social consequences (Messick, 1965). Messick emphasized the importance of construct validity, arguing "that even for purposes of applied decision making reliance upon criterion validity or content coverage is not enough" (Messick, 1975, p. 956), and that "the meaning of the measure must also be comprehended in order to appraise potential social consequences sensibly" (Messick, 1980, p. 1013). He defined test validity as an overall evaluative judgment of the adequacy and appropriateness of inferences drawn from test scores, opining that values questions arise with any approach to psychological testing whether it be norm referenced or criterion referenced, a construct-based ability test or a content-sample achievement test. This evaluative judgment of test validity is based on (a) convergent and discriminate research evidence as to the test scores interpretability in terms of the particular construct under review, (b) an appraisal of the value implications of that interpretation, (c) justification of the relevance of the construct and its utility of the particular application proposed, and (d) dealing with the potential social consequences of the proposed use as well as the actual consequences upon implementation of the testing procedure.

> Intervening in the model between test use and the evaluation of consequences is a decision matrix to emphasize the point that tests are rarely used in isolation but rather in combination with other information in broader decision systems. The decision process is profoundly influenced by social values and deserves, in its own right, massive research attention beyond the good beginning provided by utility models. (Messick, 1980, p. 1025)

Messick concluded his remarks by paraphrasing Guion: "The formulation of hypotheses is or should be applied science, the validation of hypotheses is applied methodology, but the act of making . . . [a] decision is . . . still an art" (p. 1025).

The Use of Achievement Tests in Clinical Practice

Achievement testing conducted with clinical populations is generally regarded as an extension of intelligence and aptitude testing. It provides one further means to ascertain "general ability level." Results are typically utilized for drawing inferences regarding the capacity of the individual under evaluation to apply knowledge or native intelligence in practical problem-solving situations. One equates intelligence and exposure to educational opportunity with the ability to conform with the demands of achievement testing at commensurate levels of success. Typically, one is not engaging in achievement testing with this population in anticipation of identification of potential performance discrepancies, but to gauge overall adaptive competency. The identification of any significant discrepancies would of course result in further clinical investigation. Cognitive as well as noncognitive variables would then be explored.

Achievement Test Results Applied in Neuropsychological Evaluation. Achievement tests play a definitive role in the administration of standard neuropsychological test batteries. For example, a number of extended versions of the Halstead-Reitan Neuropsychological Test Battery include an administration of the Wide Range Achievement Test or other age-appropriate screening battery within the test protocol. Data derived from such tests offer clinical utility beyond discrepancy analysis. They can be used as a method to infer an estimated level of premorbid intellectual functioning (Lezak, 1983). As basic academic skill competencies are generally not susceptible to significant deterioration in mild to moderate generalized cerebral dysfunction, standard scores derived from general achievement test measures offer one means to interpolate a coarse estimation of premorbid functioning when other means of documentation are not available.

Achievement test results can be incorporated in the pattern analysis of other neuropsychological test variables to aid in the specification of the effects of focal lesion processes. For example, problems exclusively with the spatial components of arithmetic processes in an individual manifesting no evidence of linguistic defects would help suggest a post-Rolandic lesion of the right cerebral hemisphere, when other markers of right hemisphere dysfunction are present. It is not uncommon to consider achievement test performance within the context of a formal aphasia examination as a means to extend the assessment to the integrity of lexical skill functions and writing ability.

Beyond their application in the documentation of the effects associated with focal lesion processes, such test results hold even greater potential utility in aiding in the development of hypotheses regarding functional limitations associated with cerebral dysfunction. As primary academic skill competencies are intimately related to aspects of autonomous functioning in a number of instrumental activities associated with daily living, the degree of preservation of such primary skills as reading and arithmetic abilities can be important prognostic indicators associated with long term recovery and adaptation.

Achievement Test Results Applied to Rehabilitation Assessment Methodologies. In the areas of both psychiatric and vocational rehabilitation, the specification of the degree to which core academic competencies are developed holds a number of prognostic implications. With low-level functioning indivi[illegible] the specification of primary literacy skills is an important determinant of the level of complexity of programming in which they might participate. The degree to which a learning curriculum might emphasize effective reading comprehension might be potentially exclusionary, for example.

An important component of the rehabilitation assessment is determination of the degree to which any remedial intervention might be required prior to implementing programming. Inadequate educational opportunity or underachievement related to psychosocial factors must be distinguished from developmental academic disorders and conditions which cause a loss of previously attained ability. Intervention strategies to remediate or supplant deficient academic skills are determined by the thorough analysis of their cause. Prognostically, it is important to identify those individuals functioning at their plateau versus those who have the potential to develop these skills further.

In summary, with the use of achievement testing in clinical settings the focus is typically divested towards two lines of inquiry: (a) obtaining knowledge of the degree to which basic academic skill competencies [illegible] developed in a particular individual, and (b) exam[illegible]ing individual performance within a particular area of academic performance. The basic referral question in large measure determines what armamentarium of techniques will be brought to bear in the assessment. It will also influence how test scores will be compared and interpreted.

COGNITION, METACOGNITION, AND ACHIEVEMENT TESTING

The application of cognitive theory research to educational psychology can be traced back as early as 1960 with the publication of David Ausubel's paper "The Use of Advance Organizers in the Learning and Retention of Meaningful Verbal Material," the later work of Rothkopf (1965) on mathemagenic behaviors, Ausubel's (1968) test, *Educational Psychology: A Cognitive View*, Anderson's (1972) work on how to construct achievement tests to assess comprehension, and the work of Martin and Säljö (1976a, 1976b) who argued that a description of what is learned is more important than a summary of how much is lear[illegible] (Clarke, 1982). Glaser (1981) reviewed current research in cognitive and developmental psychology addressing its potential influence on the development of new psychometric methodology. He cited Bartholomae's (1980) work on error analysis with college students in remedial writing programs and Siegler's (1976) work on rule assessment in the acquisition of scientific concepts as illustrative of the "necessary interrelationships between the analytical assessment of performance and effective instruction" (Glaser, 1981, p. 929). Interest in the assessment of mastery or competence can be traced also to developments in cognitive psychology, artificial intelligence, and language understanding. Herein the works of Chase and Simon (1973) on the chess master and the work of Larkin, McDermott, Simon, and Simon (1980) on problem solving in the area of elementary physics were cited by Glaser.

Finally, research in the realm of metacognition—the knowledge, regulation, and management of one's own cognitive processes and products (Flavell, 1976)—has led to a concern with the measurement of these self-regulatory skills in terms of predicting successful problem solving which then leads to learning. Metacognitive abilities develop with maturity, and current research in learning instruction has demonstrated that these skills may be less well developed in those individuals who have learning disabilities.

Thus, it becomes quite clear that an understanding of the learning process and its assessment can yield more fruitful data than those traditionally obtained by achievement tests. This is particularly important in light of the social-educational demands outlined by Glaser (1981) which will shape and mold the future of educational assessment:

- the shift from a selective educational system to one designed to help individuals succeed in educational programs (zero-reject system)
- the requirement for improved levels of literacy and problem-solving ability in a variety of knowledge and skill domains (minimum competency and mastery certification)
- the need to understand individual differences in the process of measurement so that abilities can be improved to facilitate further learning (cognitive, sociocultural, gender specific)

The application of cognitive and metacognitive principles with respect to the measurement of learning have been detailed in the areas of reading (Curtis, 1980; Curtis & Glaser, 1983), spelling (Henderson & Beers, 1980; Nolen & McCartin, 1984), and foreign language (Fischer, 1981; Stevenson, 1983; Terry, 1986). Curtis and Glaser (1983) describe the current level of understanding and the theoretical framework utilized to study the process of learning to read, a process which involves a complex of interrelated skills (word decoding, accessing semantic word information, sentence processing, and discourse analysis), proficiency in one affecting success in the others. The results of traditional reading achievement tests have made it impractical to diagnose reading problems in terms of remediation or instructional strategies thus far. However, current theory on efficiency in word identification, the qualitative features of semantic knowledge, and research on schemata can be utilized as a form of construct validity and thus allow measurement of achievement that reflects both the development of competence and the process of instruction. "With developing knowledge of reading it should be possible to establish standards of performance . . . [and] . . . combined enterprise representing test design based on knowledge of human learning and performance, psychometric requirements, and studies of test use should improve our ability to link testing and instruction" (Curtis & Glaser, 1983, p. 144).

Diagnostic Applications of Achievement Test Results

As an illustration of the application of cognitive and metacognitive strategies in the process of achievement testing, the remainder of this discussion focuses on an expanded level of analysis that can be undertaken in the clinical setting for purposes of both diagnosis and remediation interventions.

Reading. Assessment of the skills brought to bear by a reader in decoding words generally represents the first level of analysis in diagnostic assessment. One is interested in determining how sophisticated word attack skills may be relative to age and intellectual ability. Two types of decoding activities are typically utilized in reading: (a) a "phonetic" approach in which words are systematically analyzed based on the blend of their phonological properties, and (b) a visually based process in which whole words or word parts are immediately recognized, that is, "sight recognition" vocabulary. Typically in normal readers whole word recognition skills increasingly supplant the need to decode individual words phonologically. As the lexicon of sight recognition vocabulary increases with reading experience, semantic and contextual cues become incorporated in the reading process. It is usually only on confrontation with unfamiliar words that a reader has to resort to phonological decoding (Curtis, 1980).

A major portion of diagnostic reading assessment focuses on the sophistication and accuracy of decoding skills. This assessment is accomplished through the presentation of reading material presented as isolated phonemes, nonsense words, familiar and unfamiliar words, as well as words presented "in context," that is, in the form of sentences or complex paragraphs. At a first level of analysis the rule-out of basic visuo-perceptual dysfunction is necessary. The reader must be able to appreciate fully the visuosymbolic configuration of letters and words. Here one is concerned with the rule-out of visual-sequential and modality specific attentional deficits which could prevent the accurate assimilation of the written material. Perceptual errors such as reversals (reading "b" for "d" or "p" for "q") would also be excluded.

With the rule-out of primary perceptual dysfunction, analysis of grapheme-phoneme correspondence is undertaken. Basic decoding ability is ascertained for vowels, consonants, and consonant blends of letter combinations. Increasing the level of complexity of syllabic blends permits analysis of any sequential information-processing deficits that may be present. One is interested in the capacity not only to analyze and decode written material sequentially, but aural material as well.

There are tasks which tap auditorization or syllabication, that is, the ability to decode the component phonetic properties of a word. On the Auditory Analysis Test, for example, one is asked to say "Germany" without the "ma" sound, thus transforming the remaining syllables to "journey." Some individuals, who on a task like the Word Attack subtest of the Woodcock Reading Mastery Tests are reasonably successful in reading isolated phonemes, have great difficulty blending these same sounds into their appropriate phonological expression when confronting them in complex words. For example, when asked to read "phonological," the student struggles to isolate "pho" . . . "no" . . . "loge" . . . "ee" . . . "cal" only to pronounce the word then as "phonograph," a word more embedded in auditory memory. Frequently the effort required to analyze words laboriously in this fashion is exacted at great expense in terms of comprehension and memory for material read.

Assessment techniques which require rapid identification of words serve as a means to assess sight recognition vocabulary. Speed of recognition is not a factor controlled for in many types of reading tests. "Automatic recognition" represents the most sophisticated and efficient means of reading. Reading performed at this level taxes working memory minimally and frees the reader to focus on the semantic organization of the material for greater understanding and for committing textual information to memory. There are, however, individuals who have not attained adequate levels of sight recognition skills. They maintain a more labored phonologically based reading style. These individuals may present a variety of deficits which impede their ability to process complex visuosymbolic material. This might involve visual inattention, visuo-perceptual processing problems, spatial or gestalt recognition deficits, or weak visual memory. An analysis of the approach taken during "word attack" can be helpful in isolating the contributing deficit or deficits.

Within this context, the overall complexity of the word presented can be important. Errors encountered with relatively simple reading material can suggest problems in processing the basic visual morphology of written material. In terms of the simultaneous processing of visual input, there may be a finite limit on how complex a word can be for it to be realized. In attempts to compensate, some children "guess" at the whole word by processing only the prefix or first few syllables. Poor visual gestalt functions or whole word recognition skills are usually typified by gross lexical "word substitution" errors. Here words which share a similar visual gestalt to the word at hand are substituted, often resulting in flagrant misreading. In this regard it is necessary to rule out impulsivity as a contributing factor. The absence of other evidence of attention deficit disorder symptoms in ancillary testing or observation is particularly helpful.

Finally, comparisons of the relative efficiency of oral and silent reading under timed conditions can be potentially useful. A sample of oral reading of both word recognition material and passage material can be extremely beneficial. Dramatic improvement in passage versus isolated word reading immediately suggests the potential for the reader to compensate via the use of semantic cues. There are students whose oral reading efficiency can be significantly compromised by anxiety or inhibition. Far greater efficiency can be expressed by them in silent reading.

Spelling. Standardized spelling tests permit an opportunity to ascertain whether skills are developed at levels commensurate with age and grade level expectations. Individualized assessment of spelling ability requires obtaining a broad sample of actual oral or written spelling skills. Multiple-choice format tasks characteristic of some achievement tests are inadequate for they permit the use of opportunistic compensatory strategies that could potentially mask true spelling deficits. In assessing spelling abilities it is useful to combine both the use of graded word lists as well as a sample of spelling in context, for example a

Table 7.4. Deficits in Higher Cortical Functioning Associated with Mathematics Difficulties

Visuo-perceptual dysfunction	"Static" or "kinetic" reversals in number recognition or writing (example: reading 6 for 9) leading to calculation errors.
Spatial processing problems	Deficits in the ability to appreciate spatial properties could lead to difficulty in learning concepts such as borrowing or carrying. Failure might be seen in the linear ordering of the operations associated with long division or multiplication. Concepts associated with geometry and higher-level mathematics may be conceptually too demanding.
Sequential information processing deficits	Tasks involving complex multistep operations are failed.
Attention deficit disorder	Failure to appreciate the full ramification of a problem with impulsive errors noteworthy, i.e., missed steps or procedures in routine problem solving well within the respective area of ability.
Memory dysfunction	Failure to acquire skills reliant upon rote memorization such as "times-tables" or deficiencies in efficient discursive reasoning problems because of weak immediate memory. Persistent requests for repetition of material.
Language dysfunction	Failure to appreciate the nuances of complex "statement problems" because of the complexity of their logico-grammatical structure or failure to develop working vocabulary of mathematical terminology.

psychopathology can significantly influence general efficiency. Individuals who manifest attention deficit disorder diagnoses may be especially error prone. Their impulsivity results in inadequate assimilation of all aspects of the problem or faulty planning in that all sufficient steps for task completion are not carried out. In this regard, developmental models of pragmatic and conceptual skills associated with mathematical skills acquisition as proposed by Reisman (1982) are helpful.

At different age levels, differing cognitive styles may be brought to bear in problem resolution. More than one means to go about solving a particular problem can be chosen. The level of sophistication of the processes brought to bear in task resolution can in itself be diagnostic. Even though a correct answer is ultimately obtained, the strategies utilized in reasoning may be developmentally deficient, hence affecting overall efficiency in performance. Greater "automation" and use of "formal operations" with maturity are anticipated. Lack of expression of efficient problem-solving strategies can be diagnostically important.

Standardized achievement tests are helpful, therefore, in identifying both the failure to develop appropriate numerical reasoning or problem-solving strategies as well as in identifying their type. Multiple pathways can lead to the expression of developmental arithmetic problems, however. It is important for the assessment of mathematical ability to be tied to the larger domain of higher cognitive functioning. This would involve more rigorous assessment than a comparison with IQ scores. The identification of any associated cognitive dysfunction could affect very significantly the design of remedial or adaptive instruction. A number of discrete developmentally based higher cognitive processing problems have been identified in Table 7.4 and their functional implications discussed.

As can be seen from this brief sampling of deficits associated with higher cognitive functioning, a number of discrete deficits can follow from developmentally based or acquired cerebral dysfunction. Functional psychopathology and anxiety effects can selectively compromise performance and should be ruled out as well.

ACHIEVEMENT TESTING WITH SPECIAL POPULATIONS

Exceptional Children

Under the educational opportunity safeguards included within Section 504 of the Rehabilitation Act and P.L. 94-142 are specific components dealing with the process of evaluation. What is mandated by law is that all students who potentially have an educational disability receive a comprehensive evaluation that fairly assesses their abilities and does not discriminate against them because of cultural or racial factors or a disabling condition. Moreover, in all areas of exceptionality, federal and state legislation require the development of individualized education plans (IEPs) for handicapped students. Educational assessment data from standardized tests provides one necessary source of information used in the development of strategies for diagnostic prescriptive teaching. Here diagnostic achievement testing plays a particularly important role not only in identifying areas in need of remediation but also in placement and classification decisions. With the importance attached to assessment in the identification, diagnosis, placement, and instruction of children with disabling conditions, it is no surprise that the use of achievement tests, particularly the use of norm-referenced measures, has come under increasing criticism (Fuchs, Fuchs, Benowitz, & Barringer, 1987; Fuchs, Fuchs, Power, & Darley, 1985; LaGrow & Prochnow-LaGrow, 1982; Ysseldyke et al., 1980; Ysseldyke & Shinn, 1981).

Fuchs et al. (1987) conducted an extensive study of the 27 most well-known and commonly used tests in special education in order to determine the degree of participation of children with handicaps in the creation of test norms, and item selection, and in the establishment of their reliability and validity. Fourteen of these tests were measures of achievement classified as either screening (battery) or diagnostic (content specific). The user manual and/or technical supplement of each test was then analyzed in terms of (a) norms, (b) item development, (c) internal and test-retest reliability, and (d) concurrent and predictive validity. In only two of the achievement measures were children with handicaps included in the norming process and on only one measure were they included in item development. Otherwise, no other information was available. Such findings led the authors to state: "[I]f, in fact, test constructors have not validated their instruments for use with handicapped people, they 'should issue cautionary statements in manuals and elsewhere regarding confidence in interpretation' based on these tests" (p. 269. Note: The quotation in Fuchs is taken from Standard 14.2, p. 79, the Standards for Educational and Psychological Testing, 1985).

Numerous studies have analyzed the performance on standardized tests of academic achievement of students with learning disabilities (Caskey, 1986; Estes, Hallock, & Bray, 1985; McGue, Shinn, & Ysseldyke, 1982; Shinn, Algozzine, Marston, & Ysseldyke, 1982; Webster, 1985), behavioral disturbances (Altrows, Maunula, & LaLonde, 1986; Eaves & Simpson, 1984), and hearing impairments (Allen, White, & Karchmer, 1983; Karchmer, Milone, & Wolk, 1979; Trybus & Karchmer, 1977), as well as students who are gifted (Karnes, Edwards, & McCallum, 1986). The findings from these studies and others demonstrate empirically (a) the variability in test results across achievement measures; (b) particular item biases where low SES is a factor; (c) the influence of the examiner on the testing process; (d) the differential effect of diagnosis; and (e) the roles of time pressure, anxiety, and sex (Doolittle, 1986; Plass & Hill, 1986). It is critical that the professionals who utilize these tests be aware of the significant validity issues involved when assessing persons with disabilities or other areas of exceptionality.

Minority Children

Cautionary comments have been made also by those persons concerned with the standardized testing of minority students. Critics of the testing movement assert that tests which purport to measure achievement, among other things, are biased against certain ethnic/racial groups. Those in favor of testing regard test misuse as the real problem. Underlying the debate is the belief by the critics that the model used to assess performance and competence in society is monocultural. "A main criticism is that the model ignores the relevance of culturally different experiences that foster other equally important competencies essential to the survival of the group or individual" (Williams, 1983, p. 192). Similarly, Green and Griffore (1980) report that in one study 46% of the errors made on Gray's Oral Reading Test by minority children were due to dialect differences. Others have suggested that lack of "test-wiseness" (Millman, Bishop, & Ebel, 1965) may serve to lower the scores of minority students on tests of aptitude and achievement. Johnson (1979), commenting about the variables that may invalidate test scores for African-Americans and other minorities, wrote:

> Many factors operate to attenuate or lower test scores, and these factors tend to have their greatest effects on Blacks and other minority applicants. These include factors which affect the actual performance of individuals on the test, such as socioeconomic status, differences in educational opportunity, motivation, narrowness of content of the tests, atmosphere of the testing situation, and the perceived relevance of the test to success. They also include factors that affect the test score more directly such as the composition of the group used for item tryouts and item selection and analysis which precede the actual standardization, composition of the standard-

> ization or normative group, and the techniques and procedures employed in item construction. Also, the validity or appropriateness of tests often differ for Black and white applicants, in relation to the same future performance of criterion. (p. 3)

In addition, it has been substantiated that minority and white children are exposed to different curricula through the practice of ability tracking (Coleman, 1966; Findley, 1974; Green & Griffore, 1980; McPartland, 1969). Reviewers of the hundreds of ability grouping studies conducted since the 1920s have concluded that while superior students may benefit from this method of curricular offering, students with lower class ranking may not. The primary areas of concern are exposure to undemanding curricula and the social stigma attached to students in low-ability groups.

In a study by Abadzi (1985), the effects on both academic achievement and self-esteem of students placed in ability grouping classrooms were investigated with a population of 767 students from grades 4 to 8 in a large Texas school district. Contrary to earlier studies, her findings were that high-ability students did not maintain in the long run the performance gains made in the first year of grouping. Only the lower-level high-ability students in grouped classes were to benefit from the educational and social opportunity provided the highest-ability students. Students near the cutoff score in all groups were the ones most influenced by grouping in terms of both achievement and self-concept. Support for these findings was provided in spite of a general downward trend in performance at the end of elementary school that was characteristic of the school district's test scores and those of other districts as well. The author hypothesized that the steady drop in scores with the high-ability students may have been the result of reduced achievement motivation brought on by a "sense of invincibility, which the high status of the program combined with nonexistent exit criteria helped reinforce" (Abadzi, 1985, p. 39).

The concept of achievement motivation raised in Abadzi's conclusions has been systematically studied since the publication of David McClelland's *The Achievement Motive* (1953). This concept has been defined as a learned motive, unconscious in nature, resulting from reward or punishment for specific behavior. While studies utilizing this definition of achievement motivation have been conducted across racial groups, they have been criticized because of their ethnocentric design, methodology, and instrumentation. Castenell (1984) suggests that future research incorporate the definition espoused by Katz (1969) and Maehr (1974) which posits that (a) achievement motivation is conscious, (b) the need to achieve is universal to all groups, but (c) "because different groups have different life experiences it is likely that situations or a set of tasks will evoke different group responses" (p. 442).

This section on special populations concludes with guidelines set forth by Williams (1983) that are highly reminiscent of the recommendations put forth in 1975 and cited at the beginning of this chapter. They would appear to encompass concerns regarding the use of achievement tests regardless of students' race, color, national origin, or handicap.

> - Test constructors should foster an awareness of the limitations of the tests and the meaning attributed to test scores.
> - Test constructors should educate their consumers in selecting tests in terms of particular goals and objectives of educational evaluation.
> - Test constructors should bear responsibility for including minorities in all aspects of test development and not limit this to the standardization sample.
> - Test consumers must assume some responsibility for developing skills in administering tests and interpreting results in light of the culturally diverse experiences that pupils bring into the testing situation.
> - The educational community should minimize or eliminate intelligence testing or substitute appropriately modified assessment techniques and interpretive procedures that consider cultural differences.
> - The educational community should focus on achievement rather than intelligence or aptitude testing to eliminate pernicious connotations and unfair placement practices that limit future educational attainment and opportunity. (p. 205)

THE FUTURE OF ACHIEVEMENT TESTS

Computer Adaptive Testing

The final section of this chapter is a discussion of the growth and impact of computerized adaptive testing on the measurement of achievement and what this product of modern technology means to the field of measurement. This is a fitting topic to conclude the previous narrative because computer adaptive testing is the direct result of advances in the fields of psychometrics, mathematics, cognitive learning theory, educational measurement, human engineering, and science technology. It relies as heavily on Glaser's criterion-referenced measurement as it does on Ausubel's cognitive approach to learning, Deno's curriculum-based measurement, Messick's concern with test validity, and Anastasi's continuum of testing.

Overall, educational research and development is most currently preoccupied with enhancing the instructional value of tests, or as Haney (1985) describes it, "making testing more educational" (p. 4). He states that one need not be a dyed-in-the-wool social Darwinist to recognize that the use of standardized testing is increasing because it serves some important social functions. However, certain deficits that currently exist tend to negate the value of these tests: (a) Most testing programs violate the one nearly universal desideratum in all learning theories—in order to learn, an individual needs to receive rapid and specific feedback; (b) Most standardized tests have a very uncertain relationship to the specific teaching and learning that occurs in particular schools and classrooms; (c) The frequent concern to keep standardized testing programs secure limits their educational utility. It is these deficits, both narrowly and broadly defined, that the process of adaptive testing can be seen to rectify.

Adaptive testing is based on the premise that a measurement continuum should parallel a learning/teaching continuum, and if this learning continuum could be adequately measured by an underlying scale extending through its entire range, a student could enter and exit the measurement continuum at points appropriate to his or her current development regardless of age or grade levels (Forbes, 1986). This test development system is based on a measurement model popularly named the Rasch Model after its originator. This model is also referred to as a one-parameter model in contrast to three-parameter models of latent traits which are based not only on item difficulty (single parameter) but also on item discrimination (slope of the difficulty) and on the level of chance performance (guessing).

All item-response theory models must have an item data bank from which test items are drawn in the process of test construction. These items are computer stored and are then retrieved following a logical format. Utilizing a computer, the test can be presented to the student on a video screen with the computer keyboard serving as the response mechanism. Under such a procedure, the computer presents one preconstructed test selected from a group of such tests. The test is tailored so that the computer "jumps" the person to the appropriate item-difficulty range and then gives a preselected sequence of items based on the correctness or incorrectness of the previous response. Generally, fewer items are required to measure performance at a predetermined level of measurement error than is the case with traditional testing procedures. Computerized adaptive tests have been shown also to take less than half the testing time required by traditional achievement tests and to provide more precise ability estimates across the entire ability range. Because the ability estimates and the item parameters are calibrated on a common scale, these estimates are theoretically independent of the particular sample of persons taking the test and the particular sample of items selected by each examiner.

Seminal work done by Weiss (1980) focused on applying computerized adaptive testing to the measurement of achievement, using a methodology to extend beyond the aptitude measurement to which this type of testing had been limited previously. In addition to extending the use of item-characteristic curve theory (ICC) methods from ability testing to the problems of achievement testing, the project was also concerned with developing solutions to unique problems raised in achievement testing, that is, assessment in multiple content areas, mastery testing, the issue of stability of measurement over time, and the effects of immediate feedback as to the correctness or incorrectness of test responses. The findings of this three-year research project supported the use of ICC theory and methods and computerized adaptive testing for the measurement of achievement. However, many new questions were raised in addition to those originally addressed by the research that were in need of further study.

Finally, one of the first studies to compare and equate achievement scores from three alternative methods of testing—paper-administration, computer-administration and computerized adaptive testing—was conducted by Olson (1986) with all students in grades 3 to 6 within three California school districts. A total of 575 students were involved in the study. Results of the study indicated that (a) analysis of variance showed no significant differences among the three measures in terms of the comparability of measurement precision; (b) computerized adaptive testing (CAT) required only one fourth of the testing time required by the paper-administrated test; (c) the computerized adaptive test provided a more precise ability estimate with smaller variance than either of the other two measures; and (d) the ability estimates calculated from a 20-item CAT tended to show more precision than tests of 55 to 62 items used with the other two measures.

This section on adaptive testing concludes with the futuristic predictions raised by Hsu and Sadock (1985) in their review, *Computer-assisted Test Construction: The State of the Art*. The authors foresaw the following as commonplace in testing of the future:

1. The development of item construction theories that take advantage of artificial intelligence and the phrase recognizability of the computer.
2. The development of item banks in the area of criterion-referenced achievement tests and in conjunction with textbook publication.
3. Item calibration and test design available on microcomputer.
4. The regular use of computers in test administration.
5. The application of IRT in test design by nonmeasurement specialists.
6. The use of computerized adaptive and diagnostic testing in the classroom.

Writing about achievement tests in the 1984 edition of the *Handbook of Psychological Assessment*, Fox and Zerkin concluded: "[While] standardized tests are not perfect and can be misused and misunderstood . . . they are currently the best instruments educators have available for assessing the quality of curriculum and for individualizing and improving instructional programs for each child" (p. 130). These conclusions no longer hold.

It is no longer possible to call these standardized measures of achievement the "best" instruments available. It is hoped that the present discourse has led the reader to question practices of the present because of knowledge of the present and to look to the future with eager anticipation. Tests can be a flexible passport into that future or a rigid barrier bound to the past. It is our job as professional educators, in the broadest sense, to insure the former. When describing the failure of the testing profession to inform the public about the meaning of "objective" standardized tests, Strenio (1981) states: "At a minimum, testers have an obligation to avoid placing their particular jargon in any context that makes it even harder for the layman to interpret than it already is" (p. 65). The authors of this chapter hope that they have not been guilty of this same failing.

> "Then you should say what you mean," the March Hare went on.
>
> "I do," Alice hastily replied; "at least—at least I mean what I say—that's the same thing, you know."
>
> "Not the same thing a bit!" said the Hatter; "why, you might just as well say that 'I see what I eat' is the same thing as 'I eat what I see!' "
>
> —Lewis Carroll
> *Alice's Adventures in Wonderland*

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7

Minnesota Multiphasic Personality Inventory*

The Minnesota Multiphasic Personality Inventory (MMPI) is a standardized questionnaire which elicits a wide range of self-descriptions that are scored to give a quantitative measurement of an individual's level of emotional adjustment and attitude to test taking. Since its development by Hathaway and McKinley in 1940, not only has it become the most widely used clinical personality inventory, but it has over 6000 published research references (Alker, 1978). Thus, in addition to its clinical usefulness, it has also stimulated a vast amount of literature and has frequently been used as a measurement device in research studies.

The test format consists of 566 affirmative statements which can be answered "true" or "false." The different categories of responses can be either hand or machine scored and summarized on a profile sheet. An individual's score as represented on the graph can then be compared with the scores derived from the normative sample on which the test was originally standardized.

Presently, the MMPI has a total of 13 scales of which 3 relate to validity and 10 to clinical or personality indices (see Table 7-1). These scales are known both by their scale numbers and by scale abbreviations. In addition, there are a large number of experimental scales which have been created for research purposes, and new scales are constantly being reported in the literature. Examples of such scales include ego strength (ES), dependency (Dy), dominance (Do), prejudice (Pr), and social status (St).

The majority of MMPI questions are relatively obvious with respect to content and deal largely with psychiatric, psychological, neurological, or physical symptoms. However, some of the questions are psychologically obscure in that it is not intuitively obvious what underlying psychological process they are assessing. For example, the item "I sometimes tease animals" is empirically answered "false" more frequently by depressed subjects than normals. Thus, it was included under scale 2 (depression) even though it does not, on the surface,

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Table 7-1. Basic Minnesota Multiphasic Personality Inventory (MMPI) Scales.

Scale Name	Abbreviation	Code No.	No. of Items
Validity Scales			
Cannot say	?		
Lie	L		15
Infrequency	F		64
Correction	K		30
Clinical Scales			
Hypochondriasis	Hs	1	33
Depression	D	2	60
Hysteria	Hy	3	60
Psychopathic deviate	Pd	4	50
Masculinity-femininity	Mf	5	60
Paranoia	Pa	6	40
Psychasthenia	Pt	7	48
Schizophrenia	Sc	8	78
Hypomania	Ma	9	46
Social introversion	Si	0	70

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appear to directly assess an individual's degree of depression. For the most part, however, the statements are more direct and self-evident, such as "I wish I could be as happy as others seem to be" (true) or "I cry easily" (true), both of which also reflect an examinee's level of depression. The overall item content is extremely varied and relates to such areas as general health, occupational interests, preoccupations, morale, phobias, and educational problems (see Table 7-2).

Once a test profile has been tabulated, the scores are frequently arranged or coded in such a way as to summarize and highlight the significant peaks and valleys. However, it is extremely important to take into consideration all the scale scores of the profile. In many instances, the same scaled score on one test profile can mean something different on another profile when the elevations or lowerings of other scales are also considered. For example, an elevated scale 3 (hysteria) may indicate an individual who denies conflict, demands support from others, expresses optimism, and is somewhat interpersonally naive. However, if this elevation is also accompanied by a high 4 (psychopathic deviate), there is likely to be a strong undercurrent of repressed anger. This anger is usually expressed indirectly, and any negative effects on others are likely to be strongly denied. Thus, it is important that the clinician not utilize purely quantitative or mechanical formulas for interpreting the profile but rather examine the scores

Table 7-2. Content Classification of the MMPI with Illustrative Items.

Category	Representative Items	No. of Items
Attitudes		
Religious	I believe in a life hereafter.	19
Sexual	I am worried about sex matters.	16
Social	I am a good mixer.	72
Test taking	It is always a good thing to be frank.	15
Education	I liked school.	12
General health	I have diarrhea once a month or more.	81
Masculinity-femininity	If I were an artist I would like to draw flowers.	55
Mood	I usually feel that life is worthwhile.	56
Morale	I am certainly lacking in self-confidence.	33
Occupation	I think I would like the work of a librarian.	18
Phobias	I am afraid to be alone in the dark.	29
Preoccupations	Evil spirits possess me at times.	46
Miscellaneous	I dream frequently.	98

NOTE: Items reproduced, by permission, from Hathaway, Starke R. and McKinley, J. Charnley, *The Minnesota Multiphasic Personality Inventory,* University of Minnesota Press, Minneapolis, Minn. Copyright © 1943 by the University of Minnesota. Content categories adapted from Marks, Seeman, and Haller (1974).

within the overall context of the other scale evaluations and valleys. Not only should a patricular scale be examined within the context of the overall test configuration, but additional sources such as behavioral observations, other psychometric devices, and relevant history can be extremely helpful in increasing the accuracy, richness, and sensitivity of personality descriptions.

A further important general interpretive consideration is that the scales represent measures of personality traits rather than simply diagnostic categories. Although the scales were originally designed to differentiate normal from abnormal behavior, it is generally regarded as far more useful to consider the scales as indicating clusters of personality variables. For example, scale 2 (depression) may suggest such characteristics as mental apathy, self-depreciation, and a tendency to worry over even relatively small matters. This approach has characterized the extensive research performed on the meanings of the two highest scales (two-point code types) which are summarized in the later portions of this chapter. Rather than merely labeling a person, this descriptive approach creates a richer, more in-depth, and wider assessment of the individual being tested.

HISTORY AND DEVELOPMENT

The original development of the MMPI was begun in 1939 at the University of Minnesota by Starke R. Hathaway and J. Charnley McKinley. They wanted an instrument which could serve as an aid in assessing adult patients during routine psychiatric case workups and which could accurately determine the severity of their disturbances. Furthermore, they were interested in developing an objective estimate of the change produced by psychotherapy or other variables in a patient's life.

The basic approach during construction of the MMPI was empirical criterion keying. This refers to the development, selection, and scoring of items within the scales based on some external criterion of reference. Thus, if a clinical population was given a series of questions to answer, the individuals developing the test would select questions for inclusion or exclusion based on whether or not this clinical population answered differently from a comparison group. Even though a theoretical approach might be used initially for the development of test questions, the final inclusion of the questions would not be based on this theoretical criterion. Instead, test questions would be selected based on whether or not they were answered in a different direction from a contrasted group. For example, a test constructor may believe that an item such as "sometimes I find it almost impossible to get up in the morning" is a theoretically good statement to use in assessing depression. However, if a sample population of depressed patients did not respond to that question differently from a normative group, then the item would not be included. Thus, if a person with hysterical traits answers "true" to the statement "I have stomach pains," it is not so important whether he actually does or does not have stomach pains, rather it is more important from a test construction point of view that he says he does. In other words, the final criterion for inclusion of items within an inventory is based on whether or not these items are responded to in a significantly different manner by a specified population sample.

Using this method, Hathaway and McKinley began with an original item pool of over 1000 statements derived from a variety of different sources. These sources included previously developed scales of personal and social attitudes, clinical reports, case histories, psychiatric interviewing manuals, and personal clinical experience. The original 1000 statements were reduced and changed until there were 504 statements which were considered to be clear, readable, not duplicated, and balanced between positive and negative wording. The statements themselves were extremely varied and were purposely designed to tap as wide a number of areas as possible in an individual's life (see Table 7-2). The next step was to select different groups of normal and psychiatric patients to whom the 504 questions could be administered. The normals were primarily friends and relatives of patients at the University of Minnesota hospitals who were willing to complete the inventory. They consisted of 226 males and 315 females who were screened with several background questions including age, education, marital status, occupation, residence, and current medical status. If they were under the care of a physician at the time of the screening interview, they were excluded from the study. This group was further augmented by the inclusion of other normal subjects such as recent high school graduates, Work Progress Administration workers, and medical patients at the University of Minnesota hospitals. This composite sample of 724 individuals was closely representative in terms of age, sex, and marital status of a typical group of individuals from the Minnesota population as reflected in the 1930 census. The clinical group was comprised of patients representing the major psychiatric categories who were being treated at the University of Minnesota hospitals. These patients were divided into clear subgroups of 50 in each category of diagnosis. If there was any question regarding a patient's diagnosis or if a person had a multiple diagnosis, then he was excluded from the study. The resulting subgroups were hypochondriasis, depression, hysteria, psychopathic deviate, paranoia, psychasthenia, schizophrenia, and hypomania.

Once the normals and psychiatric patients had been administered the 504-item scale, Hathaway and McKinley could then compare their responses. If a specific item was able to correctly differentiate between these two groups, then it was included in the resulting clinical scale. For example, the item "Much of the time my head seems to hurt all over" was answered "true" by 12% of the sample of hypochondriacs and only 4% of the normals. It was thus included in the clinical scale for hypochondriasis. The comparisons, then, were between each clinical group and the group of normals rather than among the different clinical groups themselves. By use of this selection procedure, tentative clinical scales were developed.

This was still not the final step in the scale constructions. Just because the items were endorsed differently by the group of 724 Minnesota normals than by the patients from various clinical populations did not necessarily indicate that the items could then actually be used for clinical screening purposes. The next step was to attempt to cross-validate the scales. This was accomplished by selecting a new group of normals and comparing their responses with a different group of clinical patients. The items which still provided significant differences between these groups were selected for the final version of the scales. It was reasoned, then, that these items and the scales comprised of these items would thereby be valid for differential diagnosis in actual clinical settings.

Whereas this procedure describes how the original clinical scales were developed, two additional scales were also developed using slightly different approaches. The scale of masculinity-femininity (Mf) was originally intended to be able to differentiate male homosexuals from males with a more exclusively heterosexual orientation. However, there were found to be few items which could effectively perform this function. The scale was then expanded to distinguish items which were characteristically endorsed in a certain direction by the majority of males from those which were characteristically endorsed in a certain direction by females. This was accomplished in part by the inclusion of items from the

Terman and Miles I Scale (1936). The second additional scale was social introversion (Si) which was developed by Drake in 1946. It was initially developed using empirical criterion keying in an attempt to differentiate female college students who participated extensively in social and extracurricular activities from those who rarely participated. It was later generalized to reflect the relative degree of introversion for both males and females.

It soon became apparent to the test constructors that persons could alter the impression they made on the test by various test taking attitudes. Hathaway and McKinley thus began to develop several scales that could detect the types and magnitude of the different test taking attitudes which were most likely to invalidate the other clinical scales. The four scales that were developed were the cannot say (?), the lie (L), the infrequency (F), and the correction (K) scales. The cannot say scale (?) is simply the total number of unanswered questions. If a high number of these are present, it would obviously serve to reduce the validity of the overall profile. The lie scale represents a naive and unsophisticated effort on the part of the examinee to create an overly favorable impression. The items selected for this scale were those which indicated a reluctance to admit to even minor personal shortcomings. The F scale is comprised of those items that were endorsed by less than 10% of normals. A high number of scorable items on the F scale, then, reflects that the examinee is endorsing a high number of unusually deviant responses.

Perhaps the most sophisticated of the validity scales is K which reflects an examinee's degree of psychological defensiveness. The items for this scale were selected by comparing the responses of known psychiatric patients who still produced normal MMPI's (clinically defensive) with "true" normals who also produced normal MMPI's. Those items which differentiated between these two groups were used for the K scale. Somewhat later, the relative number of items endorsed on the K scale was used as a "correction" factor. The reasoning behind this is that if some of the scales were lowered because of a defensive test taking attitude, then a measure of the degree of defensiveness could be added back into the scale to compensate for this. The result would be a more accurate appraisal of the person's clinical behavior. The scales which are not given a K correction are those whose raw score still produced an accurate description of the person's actual behavior.

The MMPI was originally copyrighted and published by the University of Minnesota Press in 1943. It was later published and distributed by the Psychological Corporation (1943) along with newly developed standard manuals, forms and scoring materials. Recently (1983), it has again been published and distributed by the University of Minnesota Press and is distributed by Interpretive Scoring Systems. Over the past 40 years it has been translated into numerous languages, and it is available in many nations throughout the world.

RELIABILITY AND VALIDITY

Reliability studies performed on the MMPI have not been overly encouraging. For example, test-retest reliabilities for psychiatric patients, in which retesting was performed less than a year after the initial measure, range from a low of .50 to highs in the range of .90, with median scores in the .80s. Proponents of the MMPI have pointed out that fluctuations in test scores are to be expected. This is especially true for psychiatric populations since the effects of treatment or stabilization in a temporary crisis situation are likely to be reflected in a patient's test performance. Bergin (1971) has demonstrated that scale 2 (depression) is particularly likely to be lowered after successful treatment. Thus, test-retest reliability may actually be an inappropriate method of evaluating this scale for certain types of populations. This defense of the test's reliability is somewhat undermined by the observation that test-retest reliability is actually more stable for psychiatric populations than for normals. Whereas the median range for psychiatric patients is around .80, median reliabilities for normals are around .70. Split half reliabilities are likewise low, having an extremely wide range from .05 to .96, with median correlations in the .70s. Reliability, then, has not proved to be one of the MMPI's strong points.

Further difficulties relate to the construction of the scales themselves. One significant problem is that intercorrelations between many of the scales are quite high probably because of the extensive degree of item overlap. Sometimes the same item will be simultaneously used for the scoring of several different scales, and most of the scales have a relatively high proportion of items common to other scales. For example, scales 7 (psychasthenia) and 8 (schizophrenia) have fairly high item overlap which is reflected in correlations ranging between .64 and .87 depending on the population sampled (Dahlstrom and Welsh, 1960). Scale 8, which has the highest number of items (78), has only 16 items that are unique to it (Dahlstrom, Welsh, and Dahlstrom, 1972). Because of the high intercorrelations between scales, several factor analytic studies have been conducted which have consistently found that two major variables could account for most of the variance (Block, 1965; Dahlstrom and Welsh, 1960; Dahlstrom et al., 1972, 1975; Welsh, 1956). All of this strongly suggests that there is a high degree of redundancy regarding what the scales measure.

The fact that the different scales correlate so highly can, in part, be understood by considering that the original selection of the items for inclusion in each scale was based on a comparison of normals with different clinical groups. The items, then, were selected based on their differentiation of normals from various psychiatric populations, rather than their differentiation of one psychiatric population from another. Even though the psychiatric groups varied from the normals on several traits, this manner of scale construction did not serve to develop accurate measurements of these different traits. Rather, the scales are filled with many heterogeneous items and measure multidimensional, often poorly defined attributes. This approach has also resulted in many items being shared with other scales. In contrast, an approach in which specific psychiatric groups had been compared with one another would more likely have resulted in scales with less item overlap that could also measure more unidimensional traits.

A final difficulty relating to scale construction is the imbalance in the number of "true" as opposed to "false" items. In the L scale, all the items are scorable if answered in the "false" direction; on the K scale, 29 of 30 items are scored if answered "false"; and scales 7, 8, and 9 have a ratio of approximately 3 to 1 of "true" as compared to "false" items. The danger of this imbalance is that persons having response styles of either acquiescing ("yea saying") or disagreeing ("nay saying") will answer according to their response style rather than to the content of the items. A theoretically sound approach to item construction would have an even balance between the number of "true" and "false" answers. Some authors (Edwards, 1957, 1964; Messick and Jackson, 1961) have even suggested that test results do not reflect psychological traits as much as generalized test taking attitudes. Thus, a controversy has arisen over "content variance," in which an examinee is responding to the content of the items in such a way as to reflect psychological traits, as opposed to "response style variance," in which responses reflect more the examinee's tendency in a certain biased direction. In a review of the literature, Koss (1979) concluded that although response sets can and do exist, the examinee's tendency to respond accurately to the item content is far stronger.

These difficulties with reliability and scale construction would suggest that the MMPI's validity is questionable. Rodgers (1972) has even referred to the MMPI as a "psychometric nightmare." However, even though the strict psychometric properties are not satisfactory, this has been somewhat compensated by extensive validity studies. More specifically, the meanings of two- and three-point profile code types have been extensively researched, as have the contributions which the MMPI can make towards assessing and predicting specific problem areas. Dahlstrom et al. (1975), in Volume 2 of their revised MMPI handbook, cite 6000 studies investigating profile patterns. This number is continually increasing (see, for example, Bennet and Schubert, 1981; Conley, 1981), and past studies provide extensive evidence of the MMPI's construct validity. For example, violence in women has been associated with elevations in scales 4 (masculinity-femininity) and 5 (psychopathic deviate), and these individuals can be described as defensive, lacking contact with their impulsiveness, nonconforming, and being at variance with the stereotyped definition of femininity (Huesmann, Lefkowitz, and Eron, 1978; McCreary, 1976). A further example is that the development of alcoholism has been found to occur more frequently in persons having elevations on scales F, 4, and 9, which suggests that they are gregarious, impulsive, and less socially conforming (Hoffman, Loper, and Kammeier, 1974). Individual clinicians can consult research on code types to obtain specific personality descriptions and learn of potential problems to which a client may be susceptible. It is primarily because of these extensive validity studies that the MMPI continues to be used.

ASSETS AND LIMITATIONS

In the discussion of reliability and validity, several limitations associated with the MMPI were highlighted. These included marginally adequate reliability and problems related to the construction of the scales, such as item overlap, high intercorrelations between scales, multidimensional poorly defined scales, and imbalances between the relative proportion of "true" as opposed to "false" items. Added to these difficulties are criticisms that the test is too long and that many of the items are considered to be offensive, especially those related to sex and religion.

A significant caution related to the construction of the MMPI is that it is generally inadequate for the assessment of normal populations. The items were selected on the basis of their ability to differentiate – in a bimodal population – normals from psychiatric patients. Thus, extreme scores can be interpreted with a fairly high degree of confidence, but moderate elevations must be interpreted with appropriate caution. An elevation in the range of 1 standard deviation above the mean is more likely to represent an insignificant fluctuation of a normal population than would be the case if a normally distributed group had been used for the scale construction. This is in contrast to a test like the California Personality Inventory (CPI) which used a more evenly distributed sample (as opposed to a bimodal one) and, as a result, can make meaningful interpretations based on moderate elevations. Evaluation of normals is further complicated by the observation that many normal persons achieve high scores. Thus, neither the items themselves nor the scales were designed for the assessment of normals.

Another difficulty with the MMPI is that its organization can be misleading since the scales labels use traditional diagnostic categories. A person might read a scale such as "schizophrenia" and infer that a person with a peak on that scale therefore fits that particular diagnosis. Although it was originally hoped that the MMPI could be used to make differential psychiatric diagnoses, it was soon found that it could not adequately perform this function. Thus, even though schizophrenics may score high on scale 8, so do other psychotic groups. Also, moderate elevations can occur for normal persons. With the publication of the most recent *Diagnostic and Statistical Manual of Mental Disorders* [DSM III; American Psychiatric Association (1980)], the traditional labels upon which the scale names were based became somewhat outdated. This causes further confusion related to diagnosis since the scales reflect older categories. For example, scales 1, 2, and 3 are called the "neurotic triad," and scale 4 is labeled psychopathic deviate; yet clinicians are often faced with translating scale elevations into DSM III terminology.

In order to compensate for the difficulties related to scale labels, clinicians should become aware of the current meanings of the scales based on research rather than the meanings implied by the often misleading scale titles. This can be helped in part by the use of scale numbers rather than titles. For example, scale 8 suggests such attributes as apathy, feelings of alienation, philosophical interests, poor family relations, and unusual thought processes rather than "schizophrenia." It is the clinician's responsibility to determine which of these attributes are most characteristic of the person being evaluated. Clinicians should also be aware of the relations between scales as represented by the extensive research performed on two- and three-point code types. Usually the patterns or profiles of the scales are more useful and valid than merely considering individual scale elevations. It is this body of research which is far more significant than the work done on the original normative sample. In fact, the size (724) and representativeness (Minneapolis adults) of the normative sample have frequently been questioned. Anastasi (1982) (p. 506) suggests that it is more appropriate to view this sample as a "non-normative fixed reference group" which can be used to compare and define the different scale scores. The subsequent research performed on empirical code profiles is far more useful than the original normative scale comparisons. It is the extensiveness of research in this area which represents what is probably the strongest asset of the MMPI.

A further significant asset is the MMPI's immense popularity and familiarity within the field. Extensive research has been performed in a variety of areas, and new developments have included abbreviated forms, new scales, the use of critical items, and computerized interpretation systems. The MMPI has been translated into all the major world languages and is available in numerous countries. Normative and validity studies have been conducted on several different cultural groups (Butcher and Pancheri, 1976), which makes possible the comparison of data collected from varying cultures. In contexts where no norms have been developed, at least the test format lends itself to developing more appropriate norms which can then be used in these contexts.

Although the MMPI has been used in the assessment of persons from different cultural contexts, such assessments should be made with extreme caution. There are likely to be even larger cultural differences for a personality test such as the MMPI than for ability tests. Cultural differences would be especially pronounced if a clinician used the original Minnesota norms rather than ones developed for the particular group he was evaluating (Butcher and Pancheri, 1976). When interpreting the profiles of culturally divergent groups, clinicians should have a knowledge of the beliefs and values of that culture and should consult appropriate norms when available. There are a wide variety of possibilities as to why persons from different cultural groups score in a certain direction. Although scores may be due to the accurate measurement of different personality traits, they may also be the result of cultural tendencies to acquiesce by giving socially desirable responses, differing beliefs relating to modesty, role conflicts, or varying interpretations of the meaning of items. Profiles may also reflect the results of racial discrimination in that scales associated with anger, impulsiveness, and frustration may be elevated.

Related to the cultural issues is the importance of taking into consideration a variety of demographic variables. It has been demonstrated that age, sex, race, place of residence, intelligence, education, and socioeconomic status are all related to the MMPI scales. Often the same relative elevation of profiles can have quite different meanings when corrections are made for demographic variables. Some of the more important and well researched of these will be discussed here and should be taken into account when interpreting test profiles.

Age. Typically, elevations occur on scales 1 (hypochondriasis) and 3 (hysteria) for older normal populations (Leon, Gillum, Gillum, and Gouze, 1980). On the other hand, scales 4 (psychopathic deviate), 7 (psychasthenia), and 8 (schizophrenia) are commonly elevated for younger populations (Marks, Seeman, and Haller, 1974). As the population which is sampled becomes older, the deviations of the latter group of scales tend to decrease. A further finding has been that scale 9 (mania) is more commonly elevated in younger persons but decreases with age until it becomes the most frequent low point in older populations (Gynther and Shimkuras, 1966). As a general rule, the left side of the profile (scales 1, 2, and 3) increases with age, which parallels the trend in older persons towards greater concern with health (scales 1 and 3) and depression (scale 2). Conversely, the right side of the profile decreases with age, which parallels decreased assertiveness (scale 4), increased introversion (scales 2 and 0), and a decrease in energy level (scale 9). However, in specific cases there may also be a complex interaction with gender, health, socioeconomic status, and ethnicity. In addition to considering scale elevations related to aging, it may be helpful to evaluate individual item content. Swenson, Pearson, and Osborne (1973) provide a list of 30 items which are likely to be affected by aging such as No. 9: "I am about as able to work as I ever was" (false) and No. 261: "If I were an artist I would like to draw flowers" (true). An analysis of these items indicates that older persons generally express a decrease in hostility (No. 39, 80, 109, 282, and 438), have more "feminine" interests (No. 132 and 261), and are more dutiful, placid, and cautious (Gynther, 1979a).

A significant feature found within adolescent populations is a general elevation in many of the MMPI scales. This has led to the development of a separate set of adolescents norms (Marks et al., 1974) which should be used when interpreting an adolescent profile.

Race and Culture. In general, test results obtained from black psychiatric patients need to be interpreted with a good deal of caution. This would involve correlating as many additional sources of information as possible, including other test findings, psychosocial history, and interview data. A consistent finding within black populations is a tendency to score higher on both scales 8 (schizophrenia) and 1 (hypochondriasis). What is significant is that elevations on scale 1 may not actually reflect somatic concerns (Miller et al., 1968), and the "psychotic" profiles (scales 8 and F) of blacks could result in inaccurate interpretive descriptions of their behavior (Gynther, 1979b; Smith and Graham, 1981). Other scale elevations occurring frequently in blacks are on L, F, and 9 (mania; Gynther, 1972, 1978a; Miller et al., 1968). In a review of the literature, Gynther (1972, 1978) stressed that the most consistent finding was that normal blacks scored higher on scales F, 8 (schizophrenia), and 9 (mania). This was true regardless of age, gender, or urban versus rural environment. The MMPI scores themselves reflect higher levels of nonconformity, alienation, and impulsivity. However, these trends may be due merely to different values and perceptions rather than higher levels of maladjustment. At this point, the issue of MMPI bias against blacks has not been resolved, and further studies relating to actual behavioral predictions are needed (Pritchard and Rosenblatt, 1980).

If one assumes that blacks' scores on the MMPI are biased, there are two approaches towards diminishing the difficulties associated with scale differences between blacks' and whites' scores. One is to decrease the importance of scales F, 8, and 9 when interpreting a black person's profile. A second strategy is the use of the R scale which is comprised of 27 items to which blacks and whites respond differently (White, 1975). By means of this scale, adjustments can be made on scales F, 4, and 8 which theoretically compensate for the effects of differing cultural background.

Although black versus white scale differences are more frequently encountered in the literature, similar research has been conducted, and norms developed, for a number of other groups. This includes work on populations from Israel (Merbaum and Hefetz, 1976), Pakistan (Mirza, 1977), South Africa (Lison and Van der Spuy, 1977), Chile (Rissetti, Butcher, Agostini, Elgueta, Gaete, Marguilies, Morlans, and Ruiz, 1979), Mexico (Nunez, 1968, 1980), and Japan (Tsushima and Onorato, 1982), as well as on Mexican-Americans (Padilla and Ruiz, 1975; Quiroga and Bessner; Reilly and Knight, 1970). Whenever clinicians work with different cultural groups, they should consult the specific norms that have been developed for use with these groups, as well as become familiar with any research that may have been carried out with the MMPI on these groups. Useful sources are Butcher and Pancheri's (1976) handbook for cross-national MMPI research and a review of current cross-cultural research by Butcher and Clark (1979).

Intellectual Level. Individuals with higher intelligence and education frequently score higher on "feminine" interests (scale 5). Furthermore, scales L and F decrease as intellectual level increases (Gynther and Shimkuras, 1966). As a result, either low scores on scale 5 (masculinity-femininity) or higher elevations on the L or F scale take on increased significance with more educated populations. Thus, a man with a university education who has an average or moderate elevation (T = 50–65) on scale 5 (masculinity-femininity) may actually be more representative of men who place a strong emphasis on traditional expressions of masculinity. Likewise highly educated persons scoring moderate elevations on L or F may be more characteristic of other persons who score somewhat higher.

The advantages and cautions for using the MMPI clearly indicate that a considerable degree of psychological sophistication is necessary. Both its assets and its limitations must be understood and taken into account. The limitations are numerous and include marginally adequate reliability, problems related to scale construction, excessive length, offensive items, limited usefulness for normal populations, misleading labels for the scales, inadequacy of the original normative sample, and the necessity of considering demographic variables. However, these limitations are balanced by a number of significant assets especially the extensive research relating to the meanings of the different scales and the relations between scales. Further assets are the MMPI's familiarity in the field, the development of new norms, and extensive research relating to specific problem areas. Of central importance is the fact that the MMPI has repeatedly proved itself to be of practical value to clinicians, especially because the variables that the scales attempt to measure are meaningful and even essential areas of clinical information. Butcher (1979) has poignantly summarized the current status of the MMPI by calling it "an outmoded but as yet unsurpassed psychopathology inventory" (p. 34).

NEW DEVELOPMENTS

In addition to the standard approaches to the MMPI, a number of significant developments have served to enhance the usefulness and information which can be derived from this test. Most of these developments are also attempts to compensate for the test's deficiencies which have already been discussed. They include abbreviated forms, new scales, critical items, and computerized interpretations.

Criticism regarding the extreme length of the MMPI has led to the development of several abbreviated forms. The one which has achieved the most popularity, but also the most severe criticism (Newmark, 1981), has been Kincannon's (1968) Mini-Mult. The form consists of 71 items and was developed by omitting items which had the greatest degree of scale overlap. Scales Mf and Si were also excluded. The overall scale configurations correspond fairly closely with the standard long form of the MMPI, with correlations ranging from .60 to .89. Two major criticisms of the Mini-Mult are that scales L, F, and Ma have low correlations with corresponding long-form scales and that it underestimates extreme scores. In order to correct the first of these criticisms, Dean (1972) revised the Mini-Mult scales L, F, and Ma until they correlated at a level of .80 with their corresponding long-form scales. The resulting 86-item MMPI abbreviation has been referred to as the Midi-Mult. Another short form was developed by Spera and Robertson (1974) who attempted to correct the second criticism by including Grayson's (1951) critical items which are significant items relating to pathology. These items can be analyzed according to their individual content but also serve to make the clinical scales more sensitive to extreme dimensions of pathology. The resulting 104-item form has been called the Maxi-Mult. Whereas, both the Mini- and Midi-Mults have been found to be insensitive to extreme levels of pathology, the Maxi-Multi is good for assessing these populations (Fauschingbauer and Newmark, 1978). However, it is inadequate for mildly pathological outpatients and normal college samples, and these inadequacies have been found to be particularly pronounced in the assessment of females (Newmark, Owen, Newmark, and Fauschingbauer, 1975; Newmark and Thibodeau, 1979).

Two additional short forms have been found to be more versatile than these variations of Kincannon's Mini-Mult. The FAM (Fauschingbauer, 1974) was developed using similar methods to the Mini-Mult. However, the inclusion of significantly more items (166) and the somewhat different organization of these items have resulted in correlations of .85 or greater with the standard long form. Another short form is the MMPI-168 (Overall and Gomez-Mont, 1974) which uses only the first 168 items of the standard MMPI. The rationale for this is that most of the reliable variance in the standard MMPI can be accounted for in these initial 168 items (Overall and Gomez-Mont, 1974). Both these short forms have been found to be extremely useful with psychiatric inpatients and normal college populations, but they are somewhat deficient in the assessment of mildly pathological outpatients (Newmark and Thibodeau, 1979). Thus, the selection of which abbreviated short form to use should depend primarily on its relative appropriateness for specific populations. Whenever possible, clinicians should validate a short form they are using within their population of interest (Greene, 1983).

Since the initial publication of the MMPI, over 300 new scales have been developed. Their purpose has been to assist in evaluating the different content responses a client makes. Some of these scales have been developed for normals and are unrelated to pathology, such as dominance (Do) and social status (St). Others relate more directly to pathological dimensions, and often use the original data from Hathaway and McKinley's standardization sample. It is beyond the scope of this chapter to discuss all of the major new scales, but several of the most frequently used ones will be outlined.

One of the most popular developments has been the reorganization by Harris and Lingoes (1955, 1968) of the standard scales into more homogeneous content categories. These subscales were constructed by intuitively grouping together items which seemed to reflect a single trait or attitude. The Harris and Lingoes subscales represent a specific breakdown of the already existing scales 2, 3, 4, 6, 8, and 9, and are presented here:*

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*From *Subscales for the Minnesota Multiphasic Personality Inventory: An Aid to Profile Interpretation* by Robert E. Harris and James C. Lingoes (1968). Reprinted by permission of James C. Lingoes, Department of Psychology, University of Michigan.

Scale 2	(Depression)
D1	Subjective Depression
D2	Psychomotor Retardation
D3	Physical Malfunctioning
D4	Mental Dullness
D5	Brooding

Scale 3	(Hysteria)
Hy1	Denial of Social Anxiety
Hy2	Need for Affection
Hy3	Lassitude-Malaise
Hy4	Somatic Complaints
Hy5	Inhibition of Aggression

Scale 4	(Psychopathic Deviate)
Pd1	Familial Discord
Pd2	Authority Conflict
Pd3	Social Imperturbability
Pd4A	Social Alienation
Pd4B	Self Alienation
Pd4	Alienation (a summation of 4A and 4B)

Scale 6	(Paranoia)
Pa1	Persecutory Ideas
Pa2	Poignancy
Pa3	Moral Virtue

Scale 8	(Schizophrenia)
Sc1A	Social Alienation
Sc1B	Emotional Alienation
Sc1	Object Loss (a summation of Sc1A and Sc1B)
Sc2A	Lack of Ego Mastery, Cognitive
Sc2B	Lack of Ego Mastery, Conative
Sc2C	Lack of Ego Mastery, Defective Inhibition, and Control
Sc2	Lack of Ego Mastery (a summation of Sc2A, Sc2B, and Sc2C)
Sc3	Sensorimotor Dissociation

Scale 9	(Hypomania)
Ma1	Amorality
Ma2	Psychomotor Acceleration
Ma3	Imperturbability
Ma4	Ego Inflation

Serkownele (1975) has used a similar approach to develop subscales for scales 5 and 0. They can be used as an extension of the Harris and Lingoes scales:

Scale 5	(Masculinity-Femininity)
Mf1	Narcissism-Sensitivity
Mf2	Stereotypic Feminine Interests
Mf3	Denial of Stereotypic Masculine Interests
Mf4	Heterosexual Discomfort–Passivity
Mf5	Introspective-Critical
Mf6	Socially Retiring

Scale 0	(Social Introversion)
Si1	Inferiority–Personal Discomfort
Si2	Discomfort with Others
Si3	Staid–Personal Rigidity
Si4	Hypersensitivity
Si5	Distrust
Si6	Physical Somatic Concerns

Scoring directions for the earlier Harris and Lingoes subscales can be found in Dahlstrom et al. (1975), and scoring directions for both sets of subscales can be found in Graham (1977). Although the Harris and Lingoes subscales show high intercorrelations with the parent scales (Harris and Lingoes, (1968), the internal consistency of these scales is somewhat low (.04–.85; Gocka, 1965). Several initial validity studies are available (Boerger, 1975; Calvin, 1975; Gordon and Swart, 1973) which demonstrate their potential clinical usefulness. Validity and reliability studies are not yet available for Serkownek's (1975) subscales. The practical importance of both subscales is that they provide a useful supplement for interpreting the original scales. For example, a clinician can assess whether a person scoring high on scale 4 (psychopathic deviate) achieved that elevation primarily because of family discord (Pd 1) or authority problems (Pd 2) and social imperturbability (Pd 3). Based on this knowledge, more accurate evaluations can be made of such areas as acting out potential or response to psychotherapy.

In contrast to the attempt of Harris and Lingoes to develop subscales for already existing MMPI scales, Wiggins (1966) developed scales based on an overall analysis of the contents of the MMPI items. He began with item clusters which were based on such areas as authority conflicts and social maladjustment. These clusters were revised and refined using factor analysis and evaluations of internal consistency. The results are the following 13 scales:

SOC	Social Maladjustment
DEP	Depression
FEM	Feminine Interests
MOR	Poor Morale
REL	Religious Fundamentalism
AUT	Authority Conflict

PSY	Psychoticism
ORG	Organic Symptoms
FAM	Family Problems
HOS	Manifest Hostility
PHO	Phobias
HY	Hypomania
HEA	Poor Health

The Wiggins scales have acceptable levels of reliability, and validity studies have so far been promising (Boerger, 1975, Lachar and Alexander, 1978; Payne and Wiggins, 1972; Peteroy et al., 1982). Norms and directions for scoring are available in Graham (1977), as well as in Fowler and Coyle (1969) and Wiggins (1971). Like the Harris and Lingoes subscales, the Wiggins categories can provide additional useful information in the interpretation of the standard MMPI scales.

Two other frequently used scales are the MacAndrews (1965) scale (AMac) for alcoholism and Barron's (1953) ego strength scale (Es). Both scales were constructed using empirical methods in which items were selected based on response frequencies of a criterion group as compared to the frequencies of a suitable comparison group. The MacAndrews (1965) scale (also AMac, MAC, Mac scale) consists of 49 items which significantly differentiate between outpatient alcoholics and nonalcoholic psychiatric outpatients. Persons scoring high on this scale are characterized as uninhibited, sociable and they use repression and religion as means of attempting to control rebellious, delinquent impulses (Finney, Smith, Skeeters, and Auvenshine, 1971). The scale has been found to effectively differentiate alcoholic from other psychiatric patients (Clopton, 1978b; Clopton, Weiner, and Davis, 1980; Svanum, Levitt, and McAdoo, 1982) and to identify persons who are at a high risk of later developing alcohol-related problems (Williams, McCourt, and Schneider, 1971). However, the scale has difficulty differentiating alcohol abusers from other substance abusers (Burke and Marcus, 1977), and appropriate caution should be taken in assessing males as opposed to females since female alcoholics have consistently higher scores than males with similar difficulties (Butcher and Owen, 1978). Barron's (1953) ego strength (Es) scale consists of 68 items and was designed to assess the degree to which patients benefited from psychotherapy. However, validity studies have produced somewhat mixed results. Graham (1978) summarizes these studies by suggesting that Es is successful in predicting the response of neurotic patients to insight-oriented therapy, but is not useful for other types of patients or other kinds of treatments. In a correlational study with other tests, Harmon (1980) found that Es relates to the degree to which a person has an underlying belief in self-adequacy, along with tolerant, balanced attitudes.

An alternative method of constructing new scales is the interpretation of single items. Several attempts have been made to isolate those items which are considered critical to the presence of psychopathology. Answering in a significant direction on these items could represent serious pathology regardless of how the person responded on the remainder of the inventory. These items have been referred to as "pathognomonic items," "stop items," or more frequently, "critical items." It has been assumed that the direction in which a person responds represents a sample of the person's behavior and acts as a short scale which indicates his general level of functioning. Two of the most frequently used lists of critical items are Grayson's (1951) list of 38 items and Caldwell's (1969) more comprehensive list of 69 items (see Appendix I). Both of these were intuitively derived and are useful in differentiating patients undergoing crises from those who are not in crises (Koss, Butcher, and Hoffman, 1976). Furthermore, the Caldwell items were helpful in differentiating which category of crisis a particular patient was in (acute anxiety, depressed-suicidal, mental confusion, etc.). In contrast, the Grayson items could indicate that the person was in crisis, but they were limited primarily to being able to specify the presence of psychotic complaints (mental confusion, persecutory ideas). Attempts to establish an efficient cutoff score for differentiating normals from psychiatric patients have met with only minimal success due to the extensive response overlap between the two groups (Koss et al., 1976). It is most advantageous, then, to look at the individual content of the items in relation to what specific types of information they reveal rather than to look at the overall number of items answered.

A recent list of critical items was developed by Lachar and Wrobel (1979) for use with computerized MMPI reports. It attempts to provide a wide range in content, to possess face validity, and to result in valid samples of behavior. The list, which comprises 98 items, was developed through both empirical and intuitive procedures.

A final important development in approaches to the MMPI is the use of computerized interpretation systems. The number of such services has grown considerably since 1965 when the first system was developed by the Mayo Clinic. Major providers are the Roche Psychiatric Service Institute (RPSI), Clinical Psychological Services, Inc. (using the Caldwell Report), the Institute for Clinical Analysis (ICA), and Behaviordyne Psychodiagnostic Laboratory Service. A description and evaluation of these services is included in Buros's *Eighth Mental Measurements Yearbook* (Nos. 617–624, 1978). Each of the computerized systems has a somewhat different approach. Some provide screening, descriptive summaries, and cautions relating to treatment, whereas others are highly interpretive or may provide optional interpretive printouts for the clients themselves. The rationale behind computerized systems is that they can accumulate and integrate large amounts of information derived from the vast literature on the MMPI which even experienced clinicians cannot be expected to recall. However, serious questions have been raised regarding an increase in the possibility of misuse by untrained personnel. Computerized services are limited to standard interpretations and are not capable of integrating the unique variables that are usually encountered in dealing with clinical cases. This is a significant factor which untrained personnel may be more likely to either overlook or inadequately evaluate. In response to these issues, the American Psychological Association (APA) developed a set of guidelines to ensure the proper use of computerized interpretations (1966). It should be stressed that although computerized systems can offer information from a wide variety of accumulated data, their interpretations are still not end products. Like all test data, they need to be placed in the context of the client's overall background and current situation, and integrated within the framework of additional test data.

INTERPRETATION PROCEDURE

Seven steps in interpreting an MMPI have been recommended by Webb, McNamara, and Rodgers (1981). They should be followed with a knowledge and awareness of the implications of demographic variables such as age, culture, intellectual level, education, social class, and occupation. A summary of the relation between MMPI profiles and some of the main demographic variables including age, culture, and intellectual level has already been provided. While looking at the overall configuration of the test (step 5), clinicians can elaborate on the meanings of the different scales and the relations between scales by consulting the interpretive hypotheses associated with them. (These can be found in the sections on "Validity Scales," "Clinical Scales," and "Two-point Codes.") The discussion of the various scales and codes represents an attempt to integrate and summarize the work of a number of different clinical and research sources, the most important of whom have been Dahlstrom et al. (1972); Gilberstadt and Duker (1965); Grahahm (1977); Lachar (1974); Marks et al. (1974); and Webb et al. (1981). The seven steps in interpretation follow:

1. The examiner should initially note the length of time required to complete the test. For a mildly disturbed person with an average I.Q. and 14 years or more of education, the time for completion should be between 60 and 75 minutes. If two or more hours are required, the following interpretive possibilities must be considered: (a) major psychological disturbance, particularly a severe depression or functional psychosis; (b) below-average I.Q. or poor reading ability resulting from an inadequate educational background; or (c) cerebral impairment. If, on the other hand, an examinee finishes in less than an hour, one should suspect an invalid profile, an impulsive personality, or both. For individuals with reading difficulties, particularly certain aphasic conditions, a tape-recorded method of administration might be considered.

2. Note any erasures or pencil points on the answer sheet. The presence of a few of these signs may indicate that the person took the test seriously and

reduces the likelihood of random marking; a great number of erasures may reflect obsessive-compulsive tendencies.

3. Complete the scoring and plot the profile. Specific directions for tabulating the raw scores and converting them into profiles are provided in Appendix J. Compile additional information including I.Q. scores, relevant history, demographic variables, and observations from steps 1 and 2.
4. Arrange the test scores in the following manner:
   a) Arrange the ten clinical scales in order of descending elevation and place the three validity scales last.
   b) Using the following Welsh code symbols, indicate the relative elevation of each scale:

Range	*Elevation Symbol*
Over 99 T	**
90–99 T	*
80–89 T	"
70–79 T	'
60–69 T	–
50–59 T	/
40–49 T	:
30–39 T	#
Under 30 T	No symbol

In other words, all T scores above 99 have two asterisks (**) after them, all T scores between 90 and 99 have one asterisk after them. The following is an example of how to Welsh code a set of T scores:

Before Welch coding (step 4a):

No.	1	2	3	4	5	6	7	8	9	0			
Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	L	F	K
T score	75	60	66	65	43	80	85	92	83	50	56	63	44

After Welsh coding:

8*796"1'432–0/5:L/F–K:

This coding not only allows for a shorthand method of recording the results but also is used in many MMPI handbooks to look up profile interpretations. For example, the test profile given can be summarized as an 87, and a personality description could be looked up under that abbreviation in books such as Dahlstrom, Welsh, and Dahlstrom (1972, 1975) or in the section on two-point codes in this chapter. Mild elevations in a person's profile (T = 60–65) represent tendencies or trends in the individual's personality, although interpretations should be treated cautiously. Elevations above 70 are more strongly characteristic of the individual and are increasingly likely to represent core features of one's personality dynamics.

An equally acceptable alternative is to simply note the highest and lowest clinical scales as well as relative scores on the validity scales. Code types can be determined by looking at the two or three highest elevations. If the scores need to be summarized, they can be arranged in descending order of elevation with the validity scales presented in their original order (L, F, K) at the end. A clinician might also wish to place them in the order in which they occur on the profile sheet (L, F, K; 1, 2, 3, etc.). However, any summary of scores should always include and be described in terms of T scores.

5. Examine the overall pattern or configuration of the test and note the relative peaks and valleys. Typical configurations, for example, might include the "conversion V" typical of hysterical disorders or elevated scales 4 and 9 which reflect a high likelihood of acting out behavior. The overall configuration can then be used to amplify or modify the interpretations derived from step 4. Note especially any scales greater than 70 or less than 40 as being particularly important for the overall interpretation. The meaning of two-point code configurations can be determined by consulting the section in this chapter which discusses them. In approaching diagnosis, the discussions of both the scales and the code types attempt to use DSM III categories when possible, but sometimes traditional DSM II categories such as neurosis are also used. The tester may also wish to consult one of the MMPI handbooks listed in the recommended readings for a more complete understanding and interpretation of the profile which has been obtained.

6. Score the critical items (see Appendix I) and make note of which ones indicate important trends. It is often helpful to go over these items with the client and obtain elaborations, or to establish whether or not the person understood what the item was asking.

7. Examine the answer sheet and note which questions were omitted. A discussion with the client of why he chose not to respond might shed additional light on how he is functioning psychologically and what areas are creating conflict for him.

THE VALIDITY SCALES

The ? Scale

The ? scale is usually not considered to be a scale as such since it does not directly measure any specific personality trait. It is simply a total of the number of items which have been left unanswered throughout the entire test questionnaire. If there are less than 30 items that have been left unanswered (T = 50), the test results are considered to be valid only if the other validity scales are within normal limits. Moderate elevations, in which from 30 to 60 questions have been omitted (T = 50-70) may indicate either a reading difficulty or obsessional indecision. Additional possibilities to explain this degree of indecisiveness are the presence of extreme intellectualization, unusual interpretations of the items, or legalistic overcautiousness perhaps due to a paranoid condition. As the number of unanswered items increases above 60, the likelihood of a valid profile becomes increasingly more remote. Any questionnaire having 100 or more unanswered questions represents an invalid profile, and clinical conclusions based on the profile cannot be accurately made.

The L Scale

The L scale includes 15 items selected on the basis of face validity which indicate whether or not an individual is presenting, either consciously or unconsciously, a naively perfectionistic view of himself. The items all represent attitudes and values which, although rated highly in our culture, are rarely found in all but the most conscientious of individuals. For example, responding "false" to the statement "I do not like everyone I know" suggests an unrealistically positive self-perception. The scale was designed to identify a deliberately evasive response, although it also indicates individuals who are relatively defensive, naive, or unsophisticated. L is determined by counting the total number of "false" responses in items number 15, 45, 75, 105, 135, 165, 195, 225, 255, 285, 30, 60, 90, 120, and 150.

T = 56-63. Moderate elevations suggest a strong need to appear in a favorable light and may indicate psychological rigidity or conscious deception. These traits may be associated with limited intelligence or educational background unless they can be explained on the basis of occupation (e.g., clergy). The individual who scores in this range is likely to present himself as overly conforming and conventional, and will usually give socially approved answers concerning self-control and moral values.

T = 64-69. Individuals scoring in this range have a naive, unrealistic view of the world and utilize denial, repression, and perhaps conscious deception. They exaggerate their moral qualities and positive scruples but do so in a rigid, self-centered, and uncompromising manner. Underneath they tend to be insecure, self-critical, and frustrated, and they expend a lot of effort glossing over any flaws they see in themselves. They have little insight into their own behavior and usually make poor candidates for psychotherapy.

T = 70 or More. These scores are extremely rare and represent an intensification of the trends already mentioned. Such people are usually highly introspective and ruminative, and have difficulty establishing interpersonal relationships. This may occur in paranoid individuals (check scale 6) or during conscious deception by sociopaths.

The F Scale

The F scale consists of 64 items on which 90% of the normal population agrees. In other words, each item would be endorsed by only one out of ten normals. Representative statements are "I can easily make other people afraid of me, and sometimes do for the fun of it" (true) and "I have nightmares every few nights" (true). Thus, an elevation on the F scale represents a significant variation from the norm suggestive of nonconventional thinking in which the individual is likely to exaggerate or at least be unusually open concerning his psychological difficulties. Furthermore, the scale does not measure any one specific trait but rather a diversity of unusual responses. Increasing elevations on F are usually accompanied by heightened elevations on most of the other clinical scales.

High scores suggest the following possibilities: (1) endorsing deviant items in an attempt to intentionally look pathological, (2) a lack of cooperation, (3) random responding, (4) incorrect understanding of the items, and (5) a cry for help. Occasionally, individuals who are intensely anxious may get extremely high F scores and yet still have a generally valid overall profile. If K is correspondingly low, this pattern is sometimes referred to as "a cry for help" because of the overt and explicit admission of distress combined with the assumption on the part of the examiner that the individual is attempting to call attention to his need for treatment.

T = 55 or Less. Usually such individuals are free from stress and can be described as honest, dependable, calm, and conventional. They also tend to have narrow interests, engage in conventional thinking, and sometimes attempt to deny or minimize problems. They may even be attempting to "fake good," particularly if K is elevated.

T = 55–65. An F scale score within this range suggests independent and mildly nonconformist thinking, as well as some negativity and pessimism. If scores are in the upper part of this range, it may also reflect some degree of restlessness, instability, moodiness, and dissatisfaction.

T = 65–80. This elevation indicates markedly unconventional, unusual thinking and is typical of rebellious, antisocial, schizoid, or "bohemian" personalities. Within adult populations, a T score from 70 to 80 can reflect ego disorientation and feelings similar to psychotic or severely neurotic patients. Other possibilities which should be considered are that the individual is "faking bad," clerical errors in scoring, malingering, or a borderline state. Adolescents who are relatively normal but are struggling with identity problems and exhibiting nonconformist behavior may score within this range. This emphasizes the importance of using a different set of norms for adolescents, particularly for this scale.

T = 80 or More. The overall profile should be approached with caution, is probably invalid, and may reflect clerical errors in scoring, lack of cooperation, distortion due to confused and delusional thinking, or an overt attempt to falsely claim mental symptoms.

The K Scale

The K scale was devised to measure guardedness or defensiveness in test taking attitudes as well as a tendency to describe oneself in an overly positive manner. Individuals who score high on K are relatively without insight into their interpersonal relationships, and have a great desire to obtain the approval and confidence of others. Representative items are responding "false" to "I frequently find myself worrying about something" and "I find it hard to make talk when I meet new people." Persons scoring high may have significant underlying conflicts but are unwilling to discuss these difficulties and spend a considerable amount of effort in defensively concealing their true thoughts and feelings. This scale is in many ways similar to the L scale but differs primarily in that it is more subtle and effective. Whereas only naive, moralistic, and unsophisticated individuals would score high on L, more intelligent and psychologically sophisticated persons might have high K scores and yet be unlikely to have any significant elevation on L.

T = 45 or Less. This indicates a lack of normal defensiveness which is often associated with a poor self-concept, acute pathology, malingering, or "a cry for help." Usually the person's defenses are not functioning adequately, and he has a poor degree of emotional and behavioral controls. It is important to note, however, that persons of lower social class frequently obtain low K scores without necessarily reflecting these other characteristics. Likewise, adolescents often score low on the K scale, which indicates openness and a certain degree of self-criticism centered around a search for identity and a close examination of their personal values.

T = 50–60. Moderate elevations suggest adequately functioning defense mechanisms, self-acceptance, and good ego strength. There is usually a balance between self-disclosure and appropriate self-protection. Although such individuals are willing to admit to socially acceptable limitations, they may tend to minimize other conflicts.

T = 61–72. With increasing elevations, there occur corresponding increases in individuals' defensiveness and stronger tendencies to overlook faults in themselves, their families, and their life situation. There are also corresponding lack of insight and general resistance to psychological evaluation. Not only are these people intolerant of personal flaws and insecurities, but they also are unaccepting of unconventional or nonconformist behavior in others. Although extremely concerned that they present a positive image to others, nonetheless they are not accurately aware of many of the impressions that others have of them. They view the psychological problems of others as weaknesses and are reluctant to be placed in a patient role.

Moderate elevation on K is a positive sign for successful psychotherapy, but individuals with scores above T = 65 have difficulty benefiting from therapeutic intervention. Generally speaking, the prognosis tends to be poor with either extremely high or extremely low scores. A moderate elevation on an adolescent's profile is a contraindication of acting out.

T = 72 or More. Higher elevations show continued intensification and rigidification of the characteristics discussed under T = 61–72.

The F – K Index

The ratio between F and K can be used as an indication of "faking good" or "faking bad" and is computed by subtracting the raw score of K from that of F.

When F – K = +11 or More. This is a "fake bad" pattern and suggests a conscious attempt to look bad, for example, in malingering. It could also be a "cry for help" as a response to an acute life crisis, or it may reflect an overdramatization by a narcissistic, histrionic, self-indulging, and unstable person ("psychochondriac") who is attempting to manipulate pity and attention from others. A further possibility may be that the individual is acutely psychotic and has a distorted perception of his self as compared to the way in which others perceive him.

F – K = –11 or Less. This strongly suggests that the person is defensively minimizing any conflicts he might have in an attempt to look good. Interpretations of the clinical scales (1–0) should be evaluated keeping this in mind.

F – K = –20 or Less. This represents doubtful validity of test results because of an exaggerated need to cover up any areas of conflict. This may be the result of overt conscious deception, extreme rigidity, or a clear negativism and refusal to cooperate.

THE CLINICAL SCALES

Scale 1: Hypochondriasis (Hs)

Scale 1 attempts to assess the degree to which an individual has an undue concern with physical health. Elevations typically reflect exaggerated expressions of vague and nonspecific disorders in which subjects are covertly seeking to control and manipulate others. They will often be pessimistic, whiny, sour, and passive-aggressive, frequently making others around them miserable. Furthermore, they are egocentric, immature, and lacking in insight concerning the emotional component of their bodily complaints. Thus, not only do they focus their psychological and emotional complaints into physical channels, they also lack insight into this process. Since their degree of psychological sophistication is minimal, they have a difficult time with self-reflection, and psychotherapy with these individuals tends to be slow and difficult. Typically, they have demonstrated a high degree of skill in frustrating physicians as they demand care and attention, yet criticize and reject the help which is offered to them. The long, involved, and almost ritualistic listing of their complaints has sometimes been referred to as an "organ recital."

Scale 1 is often somewhat elevated along with scales 2, 3, and 7; this may reflect depressive conditions, anxiety states, and somatoform or dissociative disorders. A "conversion V" occurs when there are elevations on scales 1 and 3 with a significantly lower (10 points or more) scale 2. In these individuals, psychological conflicts are masked by a histrionic personality in which there is usually the presence of "somatized" complaints (see 13/31 code type). Although there tends to be a low to moderate increase in scale 1 during the presence of actual physical disease, the higher elevations are restricted to hypochondriacal traits.

Moderately Low Scale 1 (T = 40–50). These persons can be described as showing good judgment and being generally alert, capable, and responsible. Interpersonally, they may appear to others as conscientious, perhaps to the point of being moralistic. However, most interpretations of a low score on scale 1 should be made cautiously, since this primarily indicates merely a lack of physical complaints.

High Scorers (T = 65 or More). These persons are pessimistic, narcissistically egocentric, and stubborn; they manipulate others with their complaints and generally make others around them miserable as a result. Typically they have been to a large number of physicians and have rejected and criticized the "help" which has been offered to them. The symptoms are usually not reactions to immediate stress, but rather are long-standing problems. The anxiety level of such people is also usually low (check scale 7), but if it is somewhat elevated or can be increased. this improves the prognosis in psychotherapy. As scores increase above 70. there is an intensification of all these trends.

Scale 2: Depression (D)

Scale 2 includes 60 items which measure the extent to which an individual expresses worry, discouragement, and low self-esteem. The questions are centered around the five major features of depression which include brooding, physical slowness, subjective feelings of depression, mental apathy, and physical malfunctioning. An elevation on scale 2 is the most frequent peak seen with psychiatric patients when admitted to hospitals, and scale 2 provides the best single index of a person's current level of satisfaction, comfort, and security. High scorers on scale 2 tend to be seen by others as aloof and withdrawn as well as silent, retiring, and self-critical.

Although an elevation on scale 2 generally indicates the level of pessimism/optimism, the meaning of that trend varies according to the relative elevations of other scales. In establishing a differential diagnosis within the different types of "neurotic" disorders, it is particularly important to look at possible elevations on 1, 2, 3, and 7. For this reason, scales 1, 2, and 3 are often referred to as the "neurotic triad," and elevations in one of them will frequently be accompanied by elevations in the other two. It is also common to have an accompanying elevation on scale 7, which reflects that the self-devaluation and intropunitiveness of the depression also include tension and nervousness. However, moderate elevations on scales 2 and 7 are desirable for a favorable prognosis in psychotherapy since they reflect an introspective orientation as well as some awareness of personal problems. Of equal importance is that scales 2 and 7 measure the degree of psychological discomfort, pain, and anxiety the person is undergoing which can also be important motivators for change. Thus, they are often referred to as the "distress scales" (see code type 27/72). Another important configuration is an elevation on scales 2 and 8 which indicates that the depression also includes a sense of isolation, alienation, disaffiliation, and unusual thoughts (see code type 28/82).

The possibility of suicide increases when scale 2 is elevated, particularly if that elevation is accompanied by elevations in 4, 7, 8, and/or 9. However, there is no completely valid and useful "suicidal profile" as such. Certainly elevations on scales 2, 4, 7, 8, and 0 are reflective of conditions which excite or release suicidal behavior, but rigid interpretive and predictive formulas should be avoided. If there is *any* suspicion of suicidal potential raised by either test scores or any other means, additional assessment should be made as comprehensively as possible. Furthermore, specific indications of suicidal tendencies may be observed in the person's responses to the critical items that refer to guilt and suicide (see Appendix I).

Low 2 (T = 28–44). Individuals scoring low on scale 2 are likely to be active, alert, cheerful, and outgoing. They are seen by others as enthusiastic, self-seeking, and perhaps given to self-display. In certain cases, a low 2 may represent a denial of depressive feelings, particularly in a cyclothymic, labile person.

Moderate Elevations (T = 60–69). If 2 is the only elevated scale, this is usually indicative of a reactive depression resulting from a current life crisis. If the elevation typifies a more permanent component of their personality, such people tend to be pessimistic, have a narrow range of interests and be particularly adept at convincing themselves of their own helplessness and hopelessness. Furthermore, they may feel unable to work, have poor morale, and be dejected and discouraged. Others are likely to see them as aloof, timid, and inhibited.

High Elevations (T = 70–85). Often psychiatric patients with a clinically significant level of depression score in this range. Individuals with high scores tend to worry over relatively insignificant problems, and will typically feel helpless and hopeless with regard to interpersonal problem solving. Social withdrawal, indecision, worry, and pessimism are often characteristic features. At extremely high elevations (T = 80 or more), there will typically be a loss of appetite, sleep disturbances, extreme apathy, and self-deprecation with some delusional thinking. If 2 is the only high point on the profile, this probably represents a depressive response to a situational crisis. Scale 2 usually shows a significant decrease following successful therapy.

Scale 3: Hysteria (Hy)

Scale 3 is comprised of 60 items centered around assessing (1) the presence of specific physical complaints and (2) defensive denial of emotional or interpersonal difficulties. What is significant in persons with conversion disorders is that these themes occur simultaneously. In other words, such people establish a certain degree of adjustment by maintaining an exaggerated degree of optimism and channeling any personal conflicts into the body where these conflicts are indirectly expressed through physical complaints. Furthermore, they constantly demand affection and support from others, but they do so in indirect and manipulative ways. Frequently, they will have traits consistent with a histrionic personality in that they are socially uninhibited and highly visible, yet their contact with others is superficial, self-centered, and extremely naive. They often act out sexually and aggressively, with a convenient lack of insight into either their underlying motives or the impact of their behavior on others.

If there is an elevation in scale 3, the individual is unlikely to be psychotic despite accompanying elevations on scales 6 or 8. Although it is certainly possible that such a profile may in some cases still reflect a psychotic condition, this interpretation should be approached with caution. The "neurotic triad" and the "conversion V" have been mentioned in discussing scales 1 and 2 (see code types 12/21, 13/31, and 23/32). A further frequent and noteworthy profile occurs when scale 3 is accompanied by an elevation on K, particularly if scales F and 8 are lowered. Such individuals are likely to be affiliative, inhibited, and overconventional, and have an exaggerated need to be liked, and approved of, by others (see code 38/83).

Low 3 (T = 24–44). Low scorers on scale 3 are usually conventional, constricted, and controlled. They are sometimes described as socially nonparticipating, conforming, and having narrow interests.

Moderate Elevations (T = 60–69). Individuals scoring moderate elevations are likely to be well-functioning persons with some histrionic personality traits. They are often described as naive, self-centered, and having strong needs to see themselves in a favorable light. Typically, they lack insight into their interpersonal relations, and tend to be indirect and manipulative in their attempts to have their social needs satisfied by others. If scale 1 is significantly higher than 3, there will most likely be a tendency to redirect their emotional conflicts into physical complaints during times of stress.

High Elevations (T = 70–80). Higher elevations on scale 3 reflect persons who are conforming, immature, naive, childishly self-centered, and impulsive. They are demanding of affection and support, and yet seek these in covert and manipulative ways. Interpersonal communications are often used to obtain an emotional effect on others rather than to accurately convey information, and their relationships are superficial and immature. There is a lack of insight into the motivations for their behavior, which is maintained by perceiving events globally rather than attending to the specific and often relevant details of a situation. Their main defenses are denial and repression which often result in a displacement or conversion of psychological conflicts into the physical realm. Since one of their central needs is to be liked, they often respond to therapy in an enthusiastic and overly optimistic manner. However, when their defenses are challenged, they will become intolerant and attempt to manipulate the therapist into a nonconfrontive and overly supportive role. This frequently culminates in the expression of impossible demands which are made on the therapist. Their resistance to treatment tends to be whiny, and is interspersed with complaints of mistreatment by the therapist and the implication that they are being misunderstood. At times, high 3 scorers can be verbally aggressive with their core conflicts revolving around issues of dependence versus independence.

Scale 4: Psychopathic Deviate (Pd)

The 50 items in scale 4 are designed to measure general social maladjustment. More specifically, the questions deal with the individual's degree of alienation from his family, the extension of difficulties to school and to authority figures in general, social imperviousness, and alienation both from self and from society. This scale also measures the degree of impulse control, and elevations on this scale are nearly always associated with acting out behaviors. Furthermore, people with elevations on scale 4 have difficulty learning from the consequences of their behavior and spend a good deal of time trying to beat the system. A significant rationale for the development of this scale is that quite frequently, high scale 4 personality types make an excellent initial impression. As a result, they may go undetected by acquaintances and even friends until they are confronted with a situation which demands a sense of responsibility, consideration, and the expression of loyalties. This scale, then, can potentially assess such persons even though, at the time of testing, they may not be engaged in, or may not for some time have been involved with, impulsive acting out behavior.

If there is a corresponding elevation on scale 9, there will almost always be a history of consistent impulsive behavior. Not only do such individuals have a certain degree of anger and impulsiveness, they also have the energy to act on these impulses. Often their behavior occurs in such a way as to damage their families' reputation, and criminal antisocial acts are not uncommon. If elevations are, for example, between 55 and 65, and these are the relative high points, such trends would still be present, but they may be channeled in less extreme and more socially accepted manners, possibly resulting in adequate or even excellent levels of adjustment (see code type 49/94). Further significant and frequently encountered profiles are elevations on scales 4 and 8 (see 48/84 code type) suggestive of psychotic expressions of antisocial behavior, or elevations on scales 4 and 3 (see 34/43 code type) in which antisocial behavior is expressed through numerous covert and disguised means. Another common corresponding elevation is on scale 2, which suggests anxiety and guilt related to an antisocial person being caught and perhaps facing the consequences of his behavior (see code 24/42).

Low Elevations (T = 20–44). Low scores on scale 4 reflect persons who are conventional, overidentified with social status, cheerful, and good tempered. They are likely to be balanced, modest, and persistent in working towards their goals, although sometimes they have difficulties asserting themselves in heterosexual relationships.

Moderate Elevations (T = 60–69). Moderate elevations are common among adolescents (14–20 years old), and reflect attempts to formulate their separate identity and independence outside the home. Thus, the admission of alienation which the elevation suggests may be the result of an adolescent's search for identity, rather than a permanent and enduring character trait. Therefore, moderately high scores for adolescents should be handled with caution, and separate adolescent norms should always be used. However, extreme scores or other correspondingly high elevations may still reflect significant pathology. Moderate elevations are also found in counterculture groups which reflect their own as well as their peers' disregard of the values and beliefs of the mainstream culture. Graduate students also show high points on this scale, especially those in the humanities and social sciences. More positive characteristics to be found with moderate elevations include frankness, deliberateness, assertion, sociability, and individualism.

High Elevations (T = 70-85). High 4s are characterized by an angry disidentification with their family, society, or both. They have an apparent difficulty in planning ahead as well as a disregard for the consequences of their behavior. Thus, they have an inability to profit from experience, including psychotherapy. Generally, therapy is less effective for high 4 adolescents than it is for high 4 adults. Individuals scoring in this range have a consistent tendency to get into trouble, and can be described as angry, rebellious, impulsive, alienated, and strongly disliking rules and regulations. Usually, their social relationships are shallow, and they rarely develop strong loyalties. It is common to find that in the past, they have been involved in legal problems and heavy drinking, and have had poor work and marital adjustments. Sometimes they leave an initially good impression which is often described as "charming," but longer acquaintance reveals their unreliability, moodiness, and generalized resentment. Their true characteristics are often difficult to identify until a period of stress results in an outbreak of irresponsible, untrustworthy, and antisocial behavior. Usually such individuals are relatively free from conflicts and do not show anxiety until actually in the midst of serious difficulties. Although they seem to demonstrate an apparent lack of concern about potential danger at some future time, they are sensitive to, and even feel remorse when faced with, the actual consequences of their behavior.

Scale 5: Masculinity-Femininity (Mf)

Scale 5 includes 60 items having to do with general interests, vocational choices, and an activity-passivity dimension. Although it was originally designed to measure the relative degree of psychological masculinity or femininity in a male college population, it has turned out to be a far from pure measure. For example, it is definitely correlated with both education and intelligence. More specifically, there are five basic dimensions on which the items seem to be centered. These are personal and emotional stability, sexual identification, altruism, feminine occupational identification, and denial of masculine occupations. When the items are scored for females, the scale is merely inverted. Thus, elevations for either males or females can generally be seen as indicating a nonidentification with traditional masculine or traditional feminine roles.

Since scale 5 is usually not considered a clinical scale and is subject to wide fluctuations related to factors such as education, it is often not interpreted in the same manner as the more "clinically" oriented scales. It is rather used to color or flavor the meanings of other high or low points. A useful approach is to determine single peaks or code types without considering scale 5. Once interpretations have been made without this scale, then the possible implications of 5 can be included. For example, elevations on scales 3, 4, and 5 can be interpreted first by referring to scales 3 and 4 and to the 34/43 code. Later, the meaning of scale 5 can be taken into consideration within the context of scales 3 and 4, but the implications of a person's level of education, occupation, and socioeconomic status also have to be taken into account.

The issue, of course, arises as to whether or not scale elevations are a valid indicator of homosexuality. Although the scale was originally designed with the hope of diagnosing such tendencies, it has become more associated with the previously mentioned characteristics of aesthetic interests, vocational choices, and activity versus passivity. Elevations, especially extremely high ones, may in some cases reflect a homosexual orientation, but this is never sufficient in and of itself to make such a diagnosis. Furthermore, homosexuals who wish to conceal their preference can do so with relative ease since the item contents are relatively transparent with respect to the dimensions they are attempting to measure.

Within normal male populations, elevations reflect imagination, sensitivity, a wide range of cultural interests, and a tendency to be able to apply oneself to work. Furthermore, moderately high scorers are frequently seen as inner directed, clever, curious, and having good judgment and common sense. Males who score low usually typify traditional masculine interests and are seen as adventurous, easygoing, and sometimes coarse.

Females who score high are usually found in traditionally male roles and occupations, particularly the areas of mechanics and science. They are frequently perceived as being adventurous, dominating, aggressive, competitive, and confident. Low female scorers are often described as placing a high value on traditional female interests, and are usually sensitive and modest. However, extreme caution should be used in interpreting low female scores, especially for women of higher intellectual and educational levels.

A frequent pattern with males consists of elevated scales 4 and 5. Such a profile represents a nonconventional individual who is flamboyant in expressing his unconventional beliefs and often is identified with the counterculture. He may, for example, take pleasure in openly defying and challenging conventional modes of appearance and behavior. In contrast, a low 5 accompanied by a high 4 is characteristic of an exaggerated, perhaps even compulsive, display of masculinity. In females, a high 5 and 4 reflects a tendency to rebel against the traditional female role, and as the elevation of scale 4 increases, the specific expression of this rebelliousness becomes correspondingly more deviant. On the other hand, females with a high 5 and a low 4 are also angry and hostile but are unable to express these feelings directly, which thus creates a good deal of inner turmoil and conflict. In males, there is sometimes a pattern of an elevated 5, with accompanying elevations in scales 2, 7, and occasionally 4. Usually such persons have developed a life-style in which they present themselves as weak, inferior, guilty, and submissive. They are typically self-effacing, and shun any outward appearance of strength and pride. The stereotype of the withdrawn "egghead" or the self-critical school clown is representative of this profile. Whereas this pattern is found with an elevated 5 in males, females who demonstrate this style will show a valley on 5.

Males. *Low 5 (T = 26–40).* Males scoring low on scale 5 can be expected to place a high degree of emphasis on traditional expressions of masculinity. They characteristically prefer action to contemplation, and their range of interests tends to be somewhat narrow. Usually they will lack originality and have little insight into their motivations primarily because of a basic lack of interest in self-exploration. They are frequently seen by others as self-indulgent, independent, and narcissistic. In keeping with these traditional expressions of the male role, they place a high degree of emphasis on physical strength and athletic prowess. Their masculine strivings often take on an almost compulsive quality in that these strivings can be overdone and inflexible. However, the overt behaviors may represent attempts to reassure themselves of their strength, power, and control which actually may serve to conceal serious questions regarding their masculinity.

Moderate 5 (T = 41–59). Scores centering around the mean will reflect an average degree of identification with the masculine role and usually represent traditional values with regard to vocational and avocational interests.

Moderate Elevations (T = 60–75). Moderate elevations reflect aesthetic interests and an individual who is sensitive, imaginative, and expresses a variance from the culturally prescribed male role. College or seminary students usually score within this range, particularly if they have literary or artistic interests. They typically are introspective, are psychologically sophisticated, and have a wide range of interests. Their values tend to be idealistic; they are inner directed; and they have the ability to communicate their ideas clearly and effectively. In some men who score particularly high on scale 5, there is a rejection of masculinity combined with a relatively passive, effeminate, and noncompetitive personality.

High Elevations (T = More than 75). Although this may reflect an extremely high degree of artistic interest, there is usually conflict over sexual identity and sometimes homosexual trends may be present. Individuals within this range are basically passive, and there is frequently a history of marital problems due to a difficulty in assertively fulfilling their partners' needs. In some situations, extremely high 5s develop a reaction formation against passivity in which they may display an exaggerated expression of masculinity similar to a low-scoring 5.

Females. *Low 5 (T = 20–45).* This is one of the poorest scale indicators, and research relating to its meaning is generally lacking. Extreme caution should be used when making interpretations, especially for women of higher intellectual and educational levels. Some women scoring within this range are described as passive, submissive, yielding persons and may even have become living caricatures of the female stereotype. They may attempt to assume, or at least appear to assume, an extreme number of burdens which they may later use to create guilt and loyalty in others. In these cases, it is not unusual to find low 5 scores correlated with corresponding elevations in the "neurotic triad" (scales 1, 2, and 3).

Moderate 5 (T = 45–55). It is fairly frequent for women to have this as a relative low point in their overall test profiles. This is reflective of average, middle-class expressions of the culturally endorsed feminine role, which also corresponds to an average avocational interest pattern.

Moderate Elevations (T = 56–65). Women scoring within this range are frequently seen as active, assertive, and competitive in interpersonal relations.

High Elevations (T = More than 65). Women in this range are frequently described as confident, spontaneous, and uninhibited; they usually are found in traditionally masculine occupations and activities. Furthermore, they may be rebelling against the traditional female role and feel uncomfortable in many heterosexual situations. As the scale elevation increases, there is likewise an increase in aggressiveness and a certain "tough-minded" approach to the world. It is relatively rare to find this as a high point in females.

Scale 6: Paranoia (Pa)

Scale 6 includes 40 items which attempt to assess an individual's degree of suspiciousness, interpersonal sensitivity, and self-righteousness. The basic clinical picture of the paranoid personality includes delusional beliefs, ideas of reference, feelings of persecution, pervasive suspiciousness, grandiose self-beliefs, and interpersonal rigidity. In attempting to measure these variables, the scale 6 items range from questions regarding overt psychotic content to milder questions on the perceived ulterior motives of others. More specifically, the item content can be grouped around three basic categories having to do with (1) ideas of external influence, (2) poignancy, and (3) moral virtue.

With normal individuals, moderate elevations on scale 6 suggest that the person is emotional and softhearted, with an excess of personal sensitivity. However, the characteristics of low scorers are not consistent, and there are some differences between males and females. Males are frequently seen as cheerful, balanced, decisive, lacking in a strong sense of conscience, self-centered, and having a narrow range of interests. Females are usually described as balanced, mature, and reasonable. Within more disturbed populations, elevations frequently indicate the presence of delusions of self-reference, an extreme rigidity of attitude, disordered thought processes, and a grandiose self-concept.

Many of the items found in scale 6 are obviously socially undesirable, and therefore some paranoids may decide to answer them in an "unparanoid" direction. For example, the statement "Someone has control over my mind" is fairly transparent as to what it is attempting to assess and thus may not be admitted to. For this reason, the scale is considered one of the weakest, at least with regard to its original intent of detecting paranoid thinking. In fact, many extremely paranoid persons show no elevation at all. Thus, a low score does not necessarily exclude the possibility of a paranoid personality, even if the validity scales are normal. In fact, a low 6 may even be an indicator of paranoid thinking since paranoids typically attempt to hide their suspiciousness out of fear of others' reactions. This is especially true for bright and psychologically sophisticated persons. They could, for example, even mask their paranoid functioning within the context of a more socially approved group such as the Minute-men. However, if the scale is definitely elevated, this tends to be a good indicator of paranoid processes.

If there are pronounced elevations on scales 6 and 8 regardless of implications derived from elevations on other scales, this is highly suggestive of paranoid schizophrenia (see 68/86 code type). Occasionally, an elevated 6 and 3 profile occurs which indicates a repression of hostile and aggressive feelings. Overtly, these people might deny suspiciousness and competitiveness, and even see the world in naively accepting, positive, and almost Polyannaish terms. They can quickly develop comfortable, superficial relationships with relative ease. However, as the relationship's depth and closeness increase, the underlying hostility, egocentricity, and even ruthlessness become more apparent (see 36/63 code type).

Low 6 (T = 27–44). Persons with low scores are difficult to place in a clear-cut category, and there are differences between males and females. Whereas both are perceived as being balanced, males are also cheerful, decisive, lacking in a strong sense of conscience, and self-centered, with a narrow range of interests. Females are more frequently described as mature and reasonable. However, there is likely to be a high degree of variability in the characteristics of low scorers so interpretations should be made with appropriate caution. It is important to differentiate the low scores of normal persons from those of paranoid persons who are attempting to hide their suspiciousness. In these cases, paranoids can have the same features as high 6 scorers in that they are touchy, moody, overly cautious, and extremely sensitive in personal relationships. Furthermore, they are often stubborn, evasive, and wary, and they feel that dire consequences will result from revealing themselves to others. However, they tend to be somewhat better put together than high scorers, and typically find more socially acceptable ways to focus and express their paranoid traits.

Moderate Elevations (T = 60–75). As the elevation within this range increases, there is also a corresponding increase of undue interpersonal sensitivity. Even moderate criticisms from others can set off a depressive reaction in which the individual will brood over, enlarge, and ruminate on such statements. These people frequently report feelings of being limited and pressed by the social and vocational aspects of their lives. As scale 6 elevations increase, there is a correspondingly higher likelihood of outright suspiciousness, distrust, and resentment which may become focused on either real or imaginary wrongs. Their most frequent defense mechanism is the projection of blame and hostility onto others, and what hostility such individuals do express is done in a covert and indirect manner. Often, for example, they might develop a self-punishing, intropunitive role outwardly, yet arrange social situations in which others will become the victims of their indirectly expressed hostility. They can then fall back on a "what did I do?" position, thus neutralizing criticism directed at them.

High Elevations (T = More than 75). With elevations in this range, it may be important to consider the content and implications of the individual scale items to differentiate between an overt psychotic delusional system and a more coherent paranoid personality disorder. This distinction can also be aided by referring to the relative elevation of scale 8. It is often helpful to have the person describe why he responded to certain items in a particular way. If the overall profile is valid, an elevation above T = 75 is more likely to suggest a disabling level of pathology. It will certainly indicate a paranoid person who is brooding and suspicious, ruminates on grudges, and feels he has not gotten a fair deal out of life. Frequently, such people have delusions of reference, feelings of persecution, and the likelihood of fixed obsessions, compulsions, and phobias. In treatment, there is a high likelihood that they will be rigid and overly argumentative. They may use either the actual termination of treatment or the implied possibility of termination to protect their system as well as to manipulate and control the therapist.

Scale 7: Psychasthenia (Pt)

Scale 7 consists of 48 items which measure the extent of symptoms related to anxiety, irrational fears, self-devaluation, and excessive doubt. In general, it is the MMPI's best single indicator of anxiety and ruminative self-doubt. However, the items are usually fairly obvious about the information they are requesting, and a defensive orientation can easily reduce the elevation. For this reason, there is a full 1 K addition which is used as a corrective measure to counter the effects of such a defensive position.

Individuals who score high on scale 7 will typically be obsessionally worried, tense, indecisive, and unable to concentrate. They will almost always show extreme obsessional thoughts and utilize the defense mechanisms of intellectualization, rationalization, isolation, and undoing in an attempt to reduce anxiety and tension. However, high scorers on psychasthenia are not the same as individuals who utilize a compulsive defense system. In fact, many rigidly compulsive persons score low precisely because their system effectively wards off such feelings as insecurity, anxiety, and self-doubt. Within a medical context, high scale 7 scorers characteristically overreact and show an extreme amount of concern about relatively minor medical problems. They are usually seen as rigid, anxious, fearful, and agitated, and they typically have cardiac complaints or problems relating to their gastrointestinal or genitourinary systems. Within more normal populations, moderate elevations suggest persons who are dissatisfied, verbal, individualistic, and high strung. They will also tend to have perfectionistic orientations combined with excessively high standards of morality.

As with scale 2, some elevation on scale 7 reflects a favorable prognosis for psychotherapy because there is a sufficient degree of internal discomfort to increase the motivation for self-evaluation and change. These two scales are extremely important clinically since they provide an index of the degree of psychological pain the person is experiencing, and they are often referred to as the "distress scales" (see code type 27/72). However, if the scale elevation is extremely high, this may preclude talking therapy and indicate the need for medication until the individual is sufficiently relaxed to resume more effective communication. Another important consideration is the relative elevation of 7 and 8. If scale 7 is higher, it suggests that the person is continuing to struggle with, and feel anxious about, a psychotic process. However, a scale 7 which is significantly lower than scale 8 can indicate that the person has given up and allowed the psychosis to become more fixed (see code type 78/87).

Low 7 (T = 20–44). In general, an individual who scores within this range has a relaxed, alert attitude, is self-confident, and rarely worries over relatively insignificant difficulties. Even if self-referred, it is rare to see low scale 7 scorers in clinical populations. Low male scorers are frequently described as balanced, efficient, independent, relaxed, self-confident, and secure. Women who score low on scale 7 are similarly described as balanced, relaxed, and confident, but also as cheerful, alert, and placid.

Moderate Elevations (T = 60–74). Moderately high scorers tend to be conscientious, orderly, and self-critical, and to worry over minor problems. Typically, they are perfectionistic and have excessively high moral standards. As the scale elevation within this range increases (T = more than 65), there is also the likelihood of strong anxiety, tension, and worry. Rationalization and intellectualization become increasingly more prominent but are likely to be generally inefficient in controlling anxiety.

High Elevations (T = More than 75). With higher elevations, the same general patterns just discussed become even more pronounced. Furthermore, these people are often described as rigid, meticulous, religious, worrisome, and apprehensive. Elevations nearing 80 or more are likely to reflect levels of anxiety sufficiently high to disrupt the individuals' ability to perform daily routine tasks. Furthermore, they may have disabling feelings of guilt, as well as fixed obsessions, compulsions, or phobias, and may be extremely fearful and agitated. The defense mechanisms which are being utilized are unlikely to effectively bring about relief, and the constant rehashing of problems does not create effective solutions because of excessive uncertainty and indecisiveness.

Scale 8: Schizophrenia (Sc)

Scale 8 is the longest one on the MMPI and consists of 78 items which were originally intended to differentiate normals from schizophrenics. However, this differentiation has not been entirely successful primarily because the pattern of schizophrenia is highly varied, and includes complex and sometimes contradictory behavioral features. Thus, great care should be taken when attempting to make a diagnosis of schizophrenia, and other sources of data should be taken into account. Furthermore, the scale should not be interpreted too narrowly since a limited conception of its significance may lead merely to a label rather than to a more full and in-depth understanding of the individual's personality.

Scale 8 items are extremely varied and attempt to assess such factors as unusual thought processes, apathy, feelings of social alienation, poor family relations, and peculiarities of perception. Still other questions are directed towards reduced efficiency, difficulties in concentration, impulse control, a general inability to cope, and general fears and worries. There are basically three wide categories into which the items can be divided: (1) social and emotional alienation, (2) lack of ego mastery, and (3) bizarre sensory experiences.

If the individual has a pronounced elevation on scale 8, he is likely to feel alienated, misunderstood, and apart from social situations. There will be a feeling that somehow he is lacking something significant in his ability to adapt and adjust, and it is unlikely that he will have developed adequate social skills. Furthermore, he may have fundamental questions regarding his personal worth and identity. Many high scorers are painfully withdrawn, have few if any social relationships, and are highly involved in their inner fantasy life. They have a difficult time communicating as well as in maintaining coherent and focused thought processes. Even with moderate elevations, there is likely to be some difficulty thinking and communicating. Even when high scorers are making apparent sense, a person will have the feeling that he is missing the more significant aspects of what they are trying to say. Typically, they avoid making unequivocal statements and will usually not stay on any one idea for an extended length of time.

Clinically, schizophrenic patients usually score between 80 and 90. Thus, with scores below 80, a diagnosis of schizophrenia should be made cautiously. Sometimes, elevations up to 90 are found for extremely anxious patients, adolescent adjustment reactions, prepsychotics, and borderline personalities.

Elevations on scales 4 and 8 frequently occur in individuals who developed an early distrust towards the world. They usually see interpersonal relationships as dangerous and often respond with angry rebelliousness (see 48/84 code type). A rather infrequent but significant pattern which needs to be understood contains elevations on scales 8 and 9 (see 89/98 code type). Individuals with this pattern usually have an extremely difficult time dealing with others, not only because they feel alienated but also because they continually deflect any coherent attempt to focus on a situation. This pattern is extremely difficult to work with therapeutically because these people have a difficult time focusing their attention, and not only have a distorted view of the world but also have the energy to act on these distorted perceptions. Other frequently occurring profiles are the prognostic considerations related to scales 7 and 8 (see scale 7 and the 78/87 code type) and the schizoid configuration of elevated F, 2, 4, 8, and low 0 (see scale 2).

Low 8 (T = 21–44). Low scorers on scale 8 are often compliant, overly accepting of authority, concrete, and practically oriented. In addition, they are usually controlled, restrained, friendly, and adaptable.

Moderate Elevations (T = 60–74). Since scale 8 has 78 highly varied items, the personality descriptions resulting from moderate elevations likewise tend to be highly varied. Thus it is important to look at the overall scale configurations and to include other relevant data. At the lower end of this range, it is not uncommon to find benign or "neurotic" profiles. Often these individuals tend to have abstract interests, are not interested in practical matters, and are not highly involved with people. They frequently have philosophical interests and approach tasks from an innovative perspective, and others may see them as aloof and uninvolved. These latter characteristics are especially likely if there is an additional elevation on scale 0. Adolescents who are seen for evaluation frequently score in this range.

Within the upper ranges of moderate elevations, it is sometimes difficult to distinguish between a sense of general alienation or blatant psychotic content. In assessing the presence of psychotic processes, it is helpful to note whether scales F and 6 are elevated and to look at individual scale items, particularly the critical items (see Appendix I).

High Elevations (T = 75-90). If scale 8 scores are near 75, the individual typically appears unusual, unconventional, and eccentric, but can often maintain an adequate social and vocational adjustment. This is particularly true if the other clinical scales are relatively low. With higher elevations, however, these individuals become progressively more socially withdrawn and have a difficult time relating to others effectively. They often withdraw and tend to be highly invested in autistic, wish-fulfilling fantasies. In even the most basic interpersonal situations, they have a difficult time knowing what is expected of them. As the elevation reaches above 80, and if the overall profile appears valid, there is an increasing likelihood of a significant thought disorder complete with confusion and strange thoughts, beliefs, and actions.

Scale 9: Hypomania (Ma)

Scale 9 includes 46 fairly heterogeneous items which assess the relative degree of an individual's energy level, expansiveness, egotism, and irritability. The scale was originally developed using a group of psychiatric patients who had diagnoses of hypomania and mild acute mania. Their clinical syndrome involved cyclical periods of euphoria, increased irritability, and unproductive activity, much of which could be seen as distractive maneuvers designed to stave off an impending depression. The test items themselves can be broken down into general categories having to do with psychomotor retardation, amorality, imperturbability, and ego inflation.

Among normal males, high scorers are characteristically warm, enthusiastic, outgoing, and uninhibited. Furthermore, they can often be easily offended, are hyperactive and tense, and have an unusual capacity for sustained effort. Other characteristics are that they are frequently generous, affectionate, adventurous, expressive, and individualistic; they enjoy alcohol; and they are interested in national and political matters. Female normals who score relatively high tend to be frank, courageous, idealistic, and often seen by others as talkative, enthusiastic, and versatile.

A general consideration, however, is that the scale can reflect the level of energy at the time of testing and is therefore somewhat subject to fluctuations depending on the individual's mood. Of particular importance is the fact that manic patients, at the time of their initial hospitalization, are often too flighty and incoherent to take the test. When they finally calm down, there can be a strong deflation which may result in a low score on scale 9. Thus, a low score on 9 does not necessarily exclude the possibility of a manic diagnosis. However, as the scale score increases there is increasing likelihood of distractibility, narcissism, poor control, and superficiality. There may also be difficulties in interpersonal relations, aggressive impulses, and amoral behavior.

Low scorers often lack a normal degree of optimism, are listless and apathetic, have low self-esteem, and lack initiative and drive. If their scores are extremely low, this usually reflects a significant depression, even if scale 2 is not significantly elevated.

Two important profile patterns are the relation of scale 9 to scale 2 and its relation to K. Although scales 2 and 9 are usually negatively correlated, in some cases they may both be high (see code type 29/92). This may reflect several possible conditions but, in particular, suggests an agitated state in which the person is acutely aware of pressure from hostile impulses. A combined 2 and 9 elevation may also occur with certain types of organic brain lesions or in individuals with an introspective preoccupation and heightened narcissistic absorption, for example, disturbed adolescents who are experiencing "identity" problems. If scale 9 is moderately elevated and scales 2 and 7 are low, the individual may have an almost compulsive need to seek security through interpersonal power and narcissistic competitiveness. If an elevated K scale is found with an elevated 9, the individual additionally tends to be managerial, autocratic, and power hungry, but also has a high degree of compulsive energy directed towards organizing others. If, on the other hand, K is low, the individual is usually not overly defensive, but may be extremely competitive, narcissistic, and threatened by situations in which he must be submissive or dependent. His self-esteem is based on eliciting weakness and submission from others, but what he actually receives is usually a grudging deference and respect. In females, this profile is often accompanied by an exhibitionistic self-display of physical attractiveness. In therapy, there typically occur a wide range of self-display, power struggles, and a poor likelihood of success due to control issues, flightiness, and an unwillingness to look at one's inner pain and weakness.

Low 9 (T = 21–44). Low 9 scorers usually have an extremely low level of energy and are listless, apathetic, pessimistic regarding the future, and lacking in self-confidence. They may, for example, find it difficult to get out of bed in the morning as well as to maintain enough energy to function effectively throughout the day. If 9 is extremely low, this may reflect a serious depression, even though scale 2 might be within normal limits. However, a significant demographic variable is that it is more frequent to find low scores in older individuals than in younger ones. Thus, if a low score is found in a younger person, it carries greater significance since it is relatively unusual.

Moderate Elevations (T = 60-74). Moderately high scores on 9 are typical from individuals who are pleasant, energetic, enthusiastic, and sociable and who have a wide range of interests. They are usually optimistic, independent, and self-confident, particularly if there are correspondingly low scores on scales 2 and 0. Within higher elevations (65–75), it becomes somewhat difficult to distinguish a normal, energetic, active and ambitious person with a productive life, from a hypomanic who is ineffective, nonfocused, and hyperactive. Thus, the clinical interview and historical data may become particularly useful at this point.

High Elevations (T = More than 75). With higher elevations, there is an increasing probability that individuals are maladaptively hyperactive and agitated, have low impulse control, and become irritable even over relatively small obstacles and delays. They are likely to quickly develop relationships, but since they are restless and unable to remain focused for any length of time, these relationships are usually lacking in any real depth. Their enthusiasm tends to be intense but short-lived, and the expression of their energy is scattered and generally unproductive. In elevations exceeding 80, there is an increasing likelihood of characteristically manic behaviors including a flight of ideas, inflated feelings of self-importance, and hyperactive expressions such as pacing and nervous twitches.

Scale 0: Social Introversion (Si)

Scale 0 is comprised of 70 items which were selected from the responses of college students on an introversion-extroversion continuum. The scale is a fairly stable measure of the extent to which an individual participates in social events and his degree of comfort in interpersonal relations. The social introvert, as suggested by an elevation on scale 0, often has limited social skills, withdraws from many interpersonal situations, and feels uncomfortable in social interactions.

Normal males who score high on scale 0 are typically modest, inhibited, lacking in self-confidence, conforming, sensitive, submissive, and generally deficient in poise and social presence. Normal high-scoring females are modest, shy, self-effacing, sensitive, and prone to worry. Low male scorers, on the other hand, are typically sociable, expressive, exhibitionistic, socially competitive, and verbally fluent. Furthermore, they are somewhat dominant, persuasive, manipulative, and opportunistic. Females are similarly sociable, enthusiastic, talkative, assertive, and adventurous. Although low scores may suggest interpersonal warmth and a relatively high degree of comfort in social relationships, extremely low scores may reflect a person with a wide range of well-developed social techniques who has many social contacts. However, his interactions can often be characterized as flighty and superficial.

In general, scale 0 serves to color many of the other scales in terms of how comfortable and involved the individual is with interpersonal relationships. Typically a low score on 0 reduces the degree of pathology that may be suggested by other scale elevations and indicates that the person has most likely developed socially acceptable outlets for difficulties he may be experiencing. Higher scores, on the other hand, reflect a relatively low level of social adeptness and competence. This is of particular importance if scale 0 elevations are accompanied by a high 2 or 8, in which case the individual is unlikely to have developed an adequate social support system and will typically have a low level of social skills accompanied by strong feelings of social alienation.

Low 0 (T = 25–44). Low scorers are often warm, sociable, outgoing, gregarious, and involved with groups. However, extremely low scores may suggest that these people have very well-developed social techniques but perhaps have few close and meaningful relationships. Behind their somewhat well-developed external image, they may have underlying feelings of insecurity, a high need for social approval, extreme sensitivity, and unresolved conflicts regarding fears of dependency.

Moderate Elevations (T = 60–69). Moderate scorers tend to be reserved, aloof, shy, timid, retiring, and often experienced by others as difficult to know.

High Elevations (T = 70–85). Individuals who score high on scale 9 are usually acutely aware of the discomfort they feel in most social situations. They are perceived by others as shy, introverted, and anxious while around people. Typically, they have feelings of inferiority, lack self-confidence, are moody, and do not have a social support group to help them through difficulties.

TWO-POINT CODES

In this section, we will consider the meaning of the two highest scales. This approach can often assess the relationship between test patterns and indicate how these patterns relate to various classes of nontest behavior. The selection of which two-point codes to include has been based on their frequency of occurrence, the thoroughness of the research performed on them, and their relative clinical importance. Thus, some two-point codes will not be discussed.

An important consideration is that this approach is most appropriate for disturbed populations in which T score elevations are at least 70 and preferably higher. The descriptions are clearly oriented around the pathological dimensions of an individual. The two-point code descriptions, then, do not have the same divisions into low, moderate, and high elevations as the individual scores but are directed primarily towards discussions of high elevations. When considering two-point codes which are in the moderate range (T = 65–70), interpretations should be made with caution and the more extreme descriptions should be considerably modified or even excluded.

Usually, the relative elevation of one of the scales in relation to the other does not make much difference as long as the elevations are still somewhat similar in magnitude. A general approach is that if one scale is 10 points or more higher than the other, then the higher one gives more color to, or provides more emphasis for, the interpretation. Specific elaborations are made for scales in which a significant difference between their relative elevations is especially important. If the scales have an equal magnitude, then they should be given equal emphasis.

In some cases, three or more scales might be equally elevated, thereby making it difficult to clearly establish which scales represent the two-point code. In these cases, clinicians should look at the descriptions provided for other possible combinations. For example, if a particular profile had scales 2, 7, and 8 elevated, then the clinician should look up the 27/72 code as well as codes 78/87 and 28/82. The descriptions of all three of these codes can then be integrated into a more meaningful and accurate interpretation. When there are third or fourth scales that are frequently elevated along with the two-point code, they too will be discussed.

In developing meaningful interpretations it is important to continually consider the underlying significance of the elevated scales. This means taking into account such factors as the manner in which the scales interact, the particular category of psychopathology they suggest, and the recurring patterns or themes indicated. Whenever possible, DSM III classifications have been used, but the term "neurosis" is used occasionally because of its ability to summarize a wide variety of disorders and/or ability to refer to a cluster of related scales ("neurotic triad"). In describing a specific individual, there will always be some characteristics described in the code types which are highly accurate for that person and others which are not particularly relevant or accurate. Clinicians, then, will need to continually reflect on their data so as to develop descriptions that are both accurate and relevant.

12/21

Difficulties experienced by patients with the 12/21 code type revolve around physical symptoms and complaints which can be either organic or functional. Common complaints relate to pain, irritability, anxiety, physical tension, fatigue, and overconcern with physical functions. In addition to these symptoms is the presence of a significant level of depression. Their characteristic style of handling psychological conflict is through repression and attending to real, exaggerated, or imagined physical difficulties. Regardless of whether or not these physical difficulties are organically based, these individuals will exaggerate their symptoms and use them to manipulate others. In other words, they elaborate their complaints beyond what can be physically confirmed, often doing so by misinterpreting normal bodily functions. Typically they have learned to live with their complaints and use them to achieve their own needs. They lack insight, are not psychologically sophisticated, and resent any implications that their difficulties may be even partially psychological. This code pattern is more frequently encountered in males and older persons.

The three varieties of patients which this code is likely to suggest are the generalized hypochondriac, the chronic pain patient, and persons having recent and severe accidents. General hypochondriacs are likely to have significant depressive features and to be self-critical, indirect, and manipulative. If their difficulties are solely functional, they are more likely to be shy and withdrawn, whereas persons with a significant organic component are likely to be loud complainers. Furthermore, complaints are usually focused around the trunk of the body and involve the viscera, in contrast to the 13/31 code in which complaints refer more frequently to the central nervous system and peripheral limbs. When the 12/21 code is produced by chronic pain patients with an organic basis, they are likely to have given in to their pain and learned to live with it. Their experience and/or expression of this pain is likely to be exaggerated, they use it to manipulate others, and they may have a past history of drug or alcohol abuse which represents attempts at "self-medication." The most common profile associated with heavy drinkers consists of elevations in scales 1, 2, 3, and 4. Such persons will experience considerable physical discomfort, digestive difficulties, tension, depression, and hostility, and will usually have poor work and relationship histories. The third category of patient associated with 12/21 codes involves persons who are responding to recent, severe accidents. Their elevations on scales 1 and 2 reflect an acute reactive depression which occurs as a result of their response to the limiting effects of their condition.

The most frequent diagnosis with this code is hypochondriasis, and the somatic overconcern can be further supported if there is a corresponding elevation on scale 3. With a 127 profile, the likelihood of anxiety neurosis is increased. Such people will be fearful, anxious, nonassertive, dependent, and weak, and through the use of their helplessness, they will manipulate others into taking care of them. If scales 1 and 2 are elevated along with 8 and/or F, the person might be diagnosed as having a schizophrenic disorder with somatic delusions. With only moderate elevations in scale 8, the individual may still be hypochondriacal but with the presence of some mild somatic delusions, interpersonal alienation, and mild mental confusion. Less frequent patterns are 124, 126, and 126 4 which may reflect a personality disorder, especially a passive-aggressive personality experiencing depression.

13/31

The 13/31 code type is associated with the classic "conversion V" which occurs when scale 2 is significantly lower (10 points or more) than scales 1 or 3. As 2 becomes lower in relation to 1 and 3, the likelihood of a conversion disorder increases. This pattern is further suggested in males with correspondingly high scales 4 and 5, and in females with a correspondingly high 4 but lowered 5. There is typically very little anxiety experienced by persons with these profiles since they are converting psychological conflict into physical complaints. However, this can be checked by looking at the corresponding elevations of scales 2 and 7. If these are also high, it indicates that persons are experiencing anxiety and depression perhaps because their conversions are currently unable to effectively avoid their conflicts.

Persons with "conversion V's" will typically engage in extensive complaining about physical difficulties. Complaints may involve problems related to eating such as nausea, anorexia, or bulimia, and there may be the presence of vague "neurological" difficulties such as dizziness, numbness, weakness, and fatigue. However, there is often a sense of indifference and a marked lack of concern regarding these symptoms. These individuals have a strong need to appear rational and socially acceptable, yet nonetheless control others through histrionic and symptom-related means. They defensively attempt to appear as hypernormal, which is particularly pronounced if the K scale is also elevated. Usually they are extremely threatened by any hint that they are unconventional and tend to organize themselves around ideals of service to others. Regardless of the actual original cause of the complaints, there is a strong need to exaggerate them. Even if their complaints were originally caused by an organic impairment, there will be a strong functional basis to their problems. Interpersonal relationships will be superficial, with extensive repression of hostility, and oftentimes there will be an exhibitionistic flavor to their interactions. If scale 3 is higher than scale 1, this allows for the expression of a certain degree of optimism and, interestingly enough, any conversion will most likely be to the trunk of the body. Thus, patients might complain of such difficulties as gastrointestinal disorders, or diseases of the lungs or heart. Furthermore, this suggests the strong use of denial and repression. These people are passive, sociable, and dependent; they manipulate others through complaints about their "medical" problems. Conversely, if scale 3 is lower than scale 1, the person tends to be significantly more negative, and any conversion is likely to be to the body extremities such as the hands or legs. If scores are very high on scale 8, a corresponding peak on scale 1 is associated with somatic delusions.

When the "conversion V" is within the normal range (less than 70), persons will be optimistic but somewhat immature and tangential. Under stress, there will usually be an increase in their symptom-related complaints. They can be described as responsible, helpful, normal, and sympathetic.

The most frequent diagnoses with 13 codes are hypochondriasis, conversion disorder, and histrionic personality. Anxiety may be present if either scale 7 or 8 is elevated, but it is usually absent. The 13/31 profile is also found in pain patients with an organic injury whose symptoms typically worsen under stress.

14/41

The 14/41 code is encountered somewhat rarely, but it is important since persons with these elevations will be severely hypochondriacal. Their interpersonal interactions will be extremely manipulative but rarely antisocial. They will be able to maintain control over their impulses but will do so in a way which is bitter, self-pitying, and resentful of any rules and limits that are imposed on them. Furthermore, they will be egocentric, will demand attention, and will express continuous concern with their physical complaints. There will be some similarities to other high-scoring 4s in that they may have a history of alcohol abuse, drug addiction, and poor work and personal relationships. Usually, they will be resistant to therapy, although they may have a satisfactory response to short-term, symptom-oriented treatment. However, long-term therapy will be difficult and characterized by sporadic participation.

The two most frequently encountered diagnoses will be hypochondriasis and a personality disorder, especially antisocial personality. Differentiation between these two can be helped by noting the relative strength of either scale 1 or 4, as well as other related scales. Profiles involving "neurotic" features (anxiety, somatoform, dissociative, and dysthymic disorders) are characterized by a relatively higher scale 1 with 2 and/or 3 also elevated, whereas personality disorders are more strongly suggested when scale 4 is the primary high point.

18/81

Peaks on scales 1 and 8 are found with persons who present a variety of vague and unusual complaints. They may also experience confusion, disorientation, and difficulty concentrating. Focusing on their physical symptoms represents a means of organizing their thoughts, although the beliefs related to these symptoms may represent delusions. Their ability to deal effectively with stress and anxiety is extremely limited. They will experience interpersonal relationships with a considerable degree of distance and alienation. Others will perceive them as eccentric or even bizarre. They will distrust others and may disrupt their relationships because of difficulty in controlling their hostility. There may even be paranoid ideation which will probably, but not necessarily, be reflected in an elevated scale 6. For the most part, their level of insight will be poor, which will make them difficult candidates for psychotherapy.

Common scales which are elevated along with 1 and 8 are 2, 3, and/or 7. These serve to color or give additional meaning to 18/81. Thus, an elevated scale 2 will emphasize self-critical, pessimistic dimensions; 7, the presence of fears and anxiety; and 3, the likelihood of conversions and/or somatic delusions.

The 18/81 code is frequently diagnosed as schizophrenia, especially if the F scale is also high. With a normal F, hypochondriasis is an important possibility, but if scale 7 is elevated an anxiety disorder is also strongly suggested.

19/91

The 19/91 code is rarely encountered but is important in that it may suggest organic difficulties relating to endocrine dysfunction or to the central nervous system. There will be extensive complaining and overconcern with difficulties, but these patients may paradoxically attempt to deny and conceal their complaints at the same time. In other words, they may be significantly invested in avoiding confrontations relating to their complaints, yet will make a display of these techniques of avoidance. They will typically be extroverted, talkative, and outgoing, but also tense and restless. The expectations they have of themselves will be extremely high, yet their goals will be poorly defined and often unobtainable. If there is not an organic basis to their complaints, then their behavior may be an attempt to stave off an impending depression. Often this depression will be related to strong but unacceptable dependency needs.

Both hypochondriasis and manic states are frequent diagnoses and may occur simultaneously. These may be in response to, and exacerbated by, an underlying organic condition, an impending depression, or both. Corresponding elevations on scales 4 and 6 make the possibility of a passive-aggressive personality an important diagnostic consideration.

23/32

Persons with elevations on scales 2 and 3 are lacking in energy, weak, apathetic, listless, depressed, and anxious. They feel inadequate and have difficulty accomplishing their daily activities. Much of their energy is invested in excessively controlling their feelings and behavior. Although situational stress may act to increase their depression, usually this depression is long-standing, and they have learned to live with their unhappiness and general lack of satisfaction. Their level of insight is poor, they will rarely volunteer for psychotherapy, and they usually do not show significant improvement during psychotherapy. This is primarily because their main dynamic is denial and situations such as therapy represent a threat to their style of avoidance. By keeping their relationships superficial, they achieve a certain level of security. Interpersonally, they appear immature, childish, and socially inadequate.

There are some important male-female differences in the expression of this code type. Males are more ambitious, industrious, serious, and competitive, but also immature and dependent. They strive for increased responsibilities, yet also fear them. They want to appear normal and receive recognition for their accomplishments, yet they often feel ignored and their level of work adjustment is often inadequate. In contrast, females are more apathetic and weak, and experience significant levels of depression. They have usually resigned themselves to long-term unhappiness and a lack of satisfaction. Although there is often significant marital strife, they rarely seek divorce. They also rarely seek treatment and seem resigned to living with their unhappiness.

Dysthymic disorder is the most frequent diagnosis given to this code. Corresponding elevations on scales 4, 6, and 0 may provide additional information relating to the personality of these persons. With a high scale 4, there is more likely to be an angry, brooding component to their depression, with underlying antisocial thoughts, yet their external behavior is usually overcontrolled. An elevated scale 6 suggests that their depression relates to extreme interpersonal sensitivity and distrust, whereas a high 0 indicates that they are socially withdrawn and introspective. An additional diagnosis which should be considered is a major depression with psychotic features, especially if scales F and/or 8 are also elevated.

24/42

The most significant aspect of the 24/42 code is that these persons have an underlying antisocial trend to their personality with difficulty maintaining control over their impulses. However, once they act on their impulses, they experience guilt and anxiety regarding the consequences of their actions. This anxiety usually occurs too late to serve as an effective deterrent, and these individuals are unable to plan ahead effectively. The depression they experience then is probably situational, and the distress they do feel may reflect a fear of external consequences rather than an actual internalized moral code. Once the situation has subsided, there is usually further acting out. For this reason, the 24/42 code is sometimes referred to as reflecting an antisocial personality who has been caught. Although such people may promise to change and their guilt is generally authentic, their acting out is usually resistant to change. Effective therapy must include clear limits, a change in their environment, warm supports, and continual contact.

The history of persons with high scales 2 and 4 is often characterized by heavy drinking and/or drug abuse which serves as a form of self-medication for their depression. Their interpersonal relationships are poor, which is reflected in numerous family difficulties and sporadic employment. Their prospects for long-term employment are rarely favorable. These problems have often resulted in numerous legal complications. Such persons respond to their failures with self-criticism and self-doubt. The initial impression that they give may be friendly or even charming, and in a hospital setting they may attempt to manipulate the staff.

The hostility which is present with the 24/42 code may be expressed either directly or indirectly. A more direct expression is suggested if scale 6 is high, since these individuals may feel justified in externalizing their anger due to real or imagined wrongs which have been committed against them. In contrast, a low 6 may reflect a suppression or unconscious denial of hostility. If there are high energy levels suggested by a high scale 9, the persons may be extremely dangerous and volatile, and they may have committed violent behaviors.

The 24/42 code is associated with personality disorders, especially passive-aggressive or antisocial personalities. This is further strengthened if scale 6 is also high. However, this code may also reflect an adjustment disorder with a depressed mood. An important distinction to make is whether the depression is reactive or chronic. If chronic, then difficulties related to anxiety, conversions, and depression (neurotic features) will be more likely to be predominant, especially if scales 1 and 3 are also high. A reactive depression is more likely to represent an antisocial personality who has been apprehended for his impulsive acting out. If scale 4 is extremely elevated (above 90), there may be a psychotic or prepsychotic process, especially if F and 8 are also high.

26/62

The most significant feature of the 26/62 code is extreme sensitivity to real or imagined criticism. These individuals will sometimes read between the lines of what others say in such a way as to create rejection, yet their conclusions will be based on insufficient data. Even minor criticism is brooded over and elaborated upon. Usually, they have long histories of difficulties with interpersonal relationships. Others describe them as resentful, aggressive, and hostile. In order to protect themselves from the impending rejection of others, they will often reject others first which results in other people avoiding them. When they are avoided, they then have evidence that they are being rejected which gives them a justification for feeling and expressing anger. They can then blame others for their difficulties. This cycle is thus self-fulfilling and self-perpetuating, yet such people have difficulty understanding the part they play in creating the interpersonal responses which are directed towards them.

If scales 7, 8, and possibly 9 are also high, there is a greater likelihood of a psychotic or prepsychotic condition, especially paranoid schizophrenia. A more controlled, well-defined paranoid system with a generally adequate level of adjustment may be suggested when scales 2, 6, and F are only moderately elevated. Further possible diagnoses with the 26/62 code are a dysthymic disorder and, if scale 4 is also elevated, a passive-aggressive personality.

27/72

The 27/72 code is extremely common in psychiatric populations and reflects persons who are depressed, agitated, restless, and nervous. This may be accompanied by slowed speech and movements, as well as by insomnia and feelings of social and sexual inadequacy. Scales 2 and 7 reflect the relative degree of subjective turmoil the person is experiencing and therefore are often referred to as the "distress scales." Even though 27/72 persons usually express a great deal of pessimism regarding treatment and the future in general, their psychological distress is ordinarily reactive, and with time, they can be expected to improve. With most patients, the disorder took between one month and one year to develop, and if they report for treatment, it will be their first need for such intervention. The majority are married and their courtships were fairly brief, many marrying within one month of their initial dating. They can be characterized as being perfectionistic, meticulous, and having a high need for recognition. Their thinking is often obsessive, and they experience a wide variety of phobias and fears. Interpersonally they have difficulty asserting themselves, and will be self-blaming and self-punishing. They will rarely be argumentative or provocative. Their consciences are strong and inflexible, and they will often be extremely religious in a rigidly fundamental manner. Physical complaints may include weakness, fatigue, chest pain, constipation, and dizziness.

Moderate elevations on scales 2 and 7 can indicate a good prognosis for therapy, since this suggests that the person is introspective and is experiencing a sufficient amount of distress to be motivated towards change. However, if these scales are extremely high, then the person may be too agitated to be able to focus and concentrate. In such cases, medication may be necessary to relax him sufficiently enough to be able to function in a psychotherapeutic context. The presence of suicidal thoughts is a definite possibility, especially if scales 6 and 8 are also elevated, and the suicidal potential of these patients must be carefully evaluated.

The diagnoses of psychotic and "neurotic" conditions occur with equal frequency with the 27/72 code. The most likely diagnosis in the psychotic direction is either a psychotic depression or a mixed bipolar disorder, and the most important differentiating data come from the client's history. "Neurotic" patients can be either anxious or obsessive-compulsive. However, with only moderate elevations, they may be normals who are fatigued and exhausted, with a high degree of rigidity and excessive worry. This code occurs more frequently with males 27 years or older from higher educational backgrounds.

28/82

Persons with the 28/82 code complain of depression, anxiety, insomnia, fatigue, and weakness, as well as mental confusion, memory impairments, and difficulties in concentrating. They may also feel withdrawn, alienated, agitated, tense, and jumpy. Their motivation to achieve is characteristically low as is their overall level of efficiency. Often they will have fears relating to an inability to control their impulses including suicide. There may also be the presence of delusions and hallucinations, especially if scale 8 is greater than 85. This list of complaints presents a highly diverse description of attributes, only some of which may be present in any specific case. The presence or absence of these complaints must be determined by means other than mere scale elevations. These may include investigating critical items, the use of additional scales such as those developed by Harris and Lingoes, clinical interview data, and personal history. Of particular importance is the determination of the degree to which suicide is a possibility.

Most persons with the 28/82 code are diagnosed as either psychotically depressed or schizophrenic, especially if scale 8 is higher than scale 2. However, a certain percentage can be "neurotic," especially when scales 2 and 8 are only moderately elevated.

29/92

Although anxiety and depression are present with the 29/92 code, there is also a high level of energy which predominates. This energy may be associated with a loss of control, or it may also serve to defend against experiencing underlying depressive feelings. By speeding up their level of activity, these individuals can distract themselves from unpleasant depressive experiences. At times this will be successful, but they may also use alcohol in order either to relax or to decrease their depression. With moderate elevations, this code will at least reflect tension and restlessness.

If both scales are in the higher elevations, it suggests a mixed bipolar depression. However, both scales can change according to the particular phase the patient is in. This code can also reflect certain types of brain-injured patients or a cyclothymic disorder.

34/43

Persons having peaks on scales 3 and 4 are immature and self-centered with a high level of anger which they have difficulty expressing. Thus, it will often be expressed in an indirect, passive-aggressive style. Outwardly, such individuals are continually trying to conform and please other people, but they still experience a considerable degree of anger and need to find ways of controlling or discharging it. They might at times participate in vicariously acting out their aggression through developing a relationship with an individual who directly and spontaneously expresses his hostility. Such a relationship might be characterized by the 34/43 individuals' covertly encouraging and fueling the other person's angry expressions, yet on a more superficial social level, disapproving of them. Typically, these individuals will have poor insight regarding their own behavior. If scale 6 is also high, their lack of insight will be even more pronounced since their hostility will be projected onto others. Usually, past interpersonal relationships have been difficult. There may be a history of acting out, marital discord, and alcohol abuse. Conflicts relating to dependence versus independence are significant since both of these needs are intense. Females are more likely than males to have vague physical complaints. Furthermore, their relationships will be superficial, and will be characterized by naive expectations and a perfectionistic view of the world which is maintained by glossing over and denying conflicts.

The 34/43 code most clearly fits the pattern of a passive-aggressive personality. If both scales are extremely elevated (T greater than 85), then there may be fugue states in which aggressive and/or sexual impulses will be acted out.

36/63

A 36/63 code type indicates that persons are extremely sensitive to criticism, and repress their hostile and aggressive feelings. They are fearful, tense, and anxious, and may complain of physical difficulties such as headaches or stomach problems. Overtly, these people might deny suspiciousness and competitiveness, even seeing the world in naively accepting, positive, and perfectionistic terms. They can quickly and easily develop comfortable, superficial relationships. However, as the relationship's depth and closeness increase, their underlying hostility, egocentricity, and even ruthlessness become more apparent. If scale 6 is higher than scale 3 (by more than 5 points), these individuals will attempt to develop some sense of security in their lives by seeking power and prestige. Their ability to acquire personal insight is limited since they are psychologically unsophisticated and resent suggestions that their difficulties may be even partially psychological. They will usually blame their personal problems on others, which creates one of their major difficulties in relationships. In therapy, they will typically terminate abruptly and unexpectedly, and they can be ruthless, defensive, and uncooperative. If scale 3 is higher than scale 6 (by more than 5 points), their tendency to blame will be reduced, and such people will be more likely to deny any conflicts or problems. This will be consistent with a tendency to idealize both themselves and their world. They will be more likely to develop somatic complaints rather than paranoid ideation, and the chance of a psychotic process is significantly reduced.

38/83

The somewhat rare 38/83 code involves symptoms of anxiety, depression, and complaints such as headaches, gastrointestinal disturbances, and numbness. If scale 8 is significantly higher than scale 3, these individuals may also have thought disturbances including mental confusion, disorientation, difficulties with memory, and at times, delusional thinking. Although they have unusual experiences related to their thought processes and feel socially alienated, they also have strong needs to appear normal and strong needs for affection. However, they feel that if others knew how unusual their experiences were, they would be rejected. Thus, they are extremely afraid of dependent relationships. In order to protect themselves, they use extensive denial which makes their capacity for insight poor.

An important variation from the 38/83 code is when scale 3 is accompanied by an elevation on K, with low F and 8. Persons with this profile are likely to be affiliative, inhibited, and overconventional, and to have an exaggerated need to be liked and approved of by others. Frequently, they maintain an unrealistic, yet unassailable, optimism. They emphasize harmony, perhaps even at the cost of sacrificing their own needs, attitudes, and beliefs. Furthermore, high 3s with low F scores are extremely uncomfortable with anger and will avoid it at all costs. Typically they will also avoid independent decision making and many other situations in which they must exert their power. Since they have an exaggerated sense of optimism and are usually unaware of their personal conflicts, these individuals rarely appear in mental health clinics. It is almost as if any feelings of anger, tension, or defeat are intolerable. Such feelings seem to represent both a personal failure and, perhaps more importantly, a failure in their attempts at controlling their world by developing an overconventional, exaggeratedly optimistic, and inhibited stance.

A frequent diagnosis is schizophrenia, especially if 8 and F are highly elevated. When scale 3 is relatively higher than scale 8, and 8 and/or F is less than 70, somatoform or dissociative disorders (hysterical neurosis) are important considerations.

45/54

High scores on scales 4 and 5 reflect persons who are self-centered, inner directed, and not only nonconformist but likely to openly express this nonconformity in a challenging, confrontive manner. They may also have significant problems with sexual identity and experience sexual dysfunction. A further area of conflict revolves around ambivalence relating to strong but unrecognized dependency needs. Overt homosexuals who make obvious displays of their orientation may have this code, especially if scales 4 and 5 are the only peaks in an otherwise normal profile. However, the 45/54 code should in no way be considered diagnostic of homosexuality but simply, at times, consistent with such an orientation. To obtain further information associated with this or any profile in which scale 5 is a high point, it is extremely helpful to interpret the third highest scale and give it the degree of importance usually associated with the second highest point. Thus, a 456 profile might be interpreted as if it were a 46 code type.

There are some important differences between males and females having this code. Males will be openly nonconformist, but if they are from higher educational levels, they will be more likely to direct their dissatisfaction into social causes and express organized dissent towards the mainstream culture. In these cases, especially if scale 9 is moderately elevated, their pattern of elevation is sometimes referred to as the "peace corps profile." They are dissatisfied with their culture, sensitive, and aware, but they also have the energy to attempt to create change. They are often psychologically sophisticated, and can communicate clearly and openly. In contrast, elevated scales 4 and 9 accompanied by a low scale 5 suggest a high probability of sexual acting out and the probable development of a "Don Juan" type personality. These men are self-centered and have difficulty delaying their gratification, and behind their overt displays of affection is an underlying current of hostility.

Females with the 45/54 code will be openly rebelling against the traditional feminine role. Often motivating this rebellion is an intense fear related to developing dependent relationships. A further alternative interpretation is that these women are merely involved in a subculture or occupation which emphasizes traditionally male-oriented activities.

46/64

Persons with the 46/64 code type are hostile, brooding, distrustful, irritable, self-centered, and usually unable to form close relationships. They have significant levels of social maladjustment often related to continually blaming others for their personal faults. This style of blaming prevents them from developing insight into their own feelings and behavior, since they are constantly focusing on others' behavior rather than their own. They lack self-criticism, and are highly defensive and argumentative especially if L and K are also high. Although they lack self-criticism, they are highly sensitive to real or imagined criticism from others, often inferring hostility or rejection when this was not actually intended. In order to avoid rejection and maintain a certain level of security, they become extremely adept at manipulating others. Often they will have a history of drug addiction or alcohol abuse.

Frequent corresponding high points are on scales 2, 3, and/or 8. Males with high 8s are often psychotic, especially paranoid schizophrenic or prepsychotic, but with 2 and/or 3 also elevated, the chances of a borderline condition are significantly increased. These men are likely to be angry and have significant conflicts relating to their own denied, but strong, needs for dependency. They are likely to rebel against authority figures and may use suicidal threats as a means of manipulating others. Females with a 46/64 code type may be psychotic or prepsychotic, but they are more often passive-aggressive personalities. If scale 3 is also elevated, they will have intense needs for affection and will be egocentric and demanding.

47/74

Persons with high scores on scales 4 and 7 experience guilt over their behavior, and are brooding and resentful. Although they are frequently insensitive to the feelings of others, they are intensely concerned with their own responses and feelings. They justify this insensitivity because they feel rejected or restricted by others. Their behavioral and interpersonal difficulties follow a predictable cycle in which they will alternately express anger and then feel guilty over their behavior. While they feel angry they may have little control over their behavior, which results in impulsive acting out. This is then followed by a phase of excessive overcontrol accompanied by guilt, brooding, and self-pity. Frustrated by these feelings, they may then attempt to selfishly meet their needs through such means as alcohol abuse, promiscuity, or aggressive acting out. Thus the cycle continues and is usually fairly resistant to change. These persons respond to limit setting with anxiety and resentfulness, often either testing the limits or completely ignoring them. This frequently leads to legal problems and to difficulties in their work and home relationships. Although they do feel genuine and even excessive guilt and remorse for their behavior, their self-control is still inadequate and their acting out continues. This is a chronic pattern, and therapeutic attempts to decrease the anxiety of these individuals may actually result in an increase in their acting out because the control created by their guilt and remorse is diminished. Diagnostically, the 47/74 type is most likely to be either an antisocial personality or experiencing an anxiety disorder.

48/84

Persons with the 48/84 code are strange, eccentric, and emotionally distant, and have severe problems with adjustment. Their behavior is unpredictable and erratic, and may involve strange sexual responses. Usually there will be antisocial behavior resulting in legal complications, and these individuals are nonconforming, lack empathy, and are impulsive. Sometimes they will be members of strange religious cults or unusual political organizations. In their early family histories, they learned that relationships were dangerous because of constant confrontation with intense family conflicts. They were rejected and, as a result, felt alienated and hostile, sometimes attempting to compensate with counterrejection and other forms of retaliation. Their academic and later work performance has usually been erratic and characterized by underachievement. In interpersonal relationships, their judgment is generally poor and their style of communication is likely to be inadequate. Often others feel as if they are missing important elements or significant connotations of what the 48/84 is saying, but they can't figure out exactly what or why.

If F is elevated with a low scale 2, these individuals are typically aggressive, cold, and punitive, and have a knack for inspiring guilt and anxiety in others. Often they take on roles in which such behavior is socially sanctioned, for example, a rigid law enforcement officer, an overzealous clergyman, or a school disciplinarian. Their behavior may range all the way from being merely stern, punitive, and disapproving to encompassing actual clinical sadism. Underneath these overt behaviors, they usually have a deep sense of alienation, vulnerability, and loneliness, which may give rise to feelings of anxiety and discomfort.

Criminal behavior occurs frequently in males with a 48/84 code type, especially with an elevated scale 9. The crimes are likely to be bizarre, and often extremely violent, involving homicide and/or sexual assault. These behaviors are usually impulsive, poorly planned, without apparent reason, and generally self-defeating, eventually resulting in self-punishment. Females are less likely to act criminally, but their relationships will usually be primarily sexual and they will rarely become emotionally close. Often they will form relationships with men who are significantly inferior to themselves and who could be described as losers.

The most likely diagnosis is a schizoid or paranoid personality. However, a psychotic reaction – often paranoid schizophrenia – is also common, especially with elevations on scale 6.

49/94

Persons with 49/94 codes not only feel alienated and have antisocial tendencies, but also have the energy to act on them. They can be described as self-indulgent, sensation seeking, impulsive, oriented towards pleasure, irritable, extroverted, violent, manipulative, and energetic. They have poorly developed consciences, with a marked lack of concern for rules and conventions. Since they are free from anxiety, talkative, and charming, they can often make a good initial impression. However, their relationships are usually shallow because any sort of deeper contact with them brings out the more problematic sides of their personality. An investigation of their past history typically reveals extensive legal, family, and work-related difficulties. The 49/94 code, when found in persons over age 30, suggests that this pattern is highly resistant to change. In adolescent males, it is associated with delinquency.

There are numerous difficulties encountered in therapy with these persons. They are unable to focus for any length of time and are constantly embarking on often irrelevant tangents. Furthermore, they have difficulty delaying their gratification and usually do not learn from experience. They will often be irritable, and if confronted by a therapist, their fairly extensive hostility will be expressed. Thus, therapy is likely to be slow, frustrating, and often unproductive.

With a correspondingly low 0, this code is likely to reflect a person with highly developed social techniques who will use these skills to manipulate others. Thus, he may be involved in elaborate, antisocial "con" games. If scale 3 is correspondingly high, it decreases the chance of acting out. In these cases, the expression of hostility is likely to be similar to that of the 34/43 code in that it will be indirect and often passive-aggressive. When scale 6 is elevated along with scales 4 and 9, extreme caution should be taken since these individuals will be very dangerous and have poor judgment. Their acting out will often be violent and bizarre, and will appear justified to themselves because of strong feelings of resentment towards others.

The most likely diagnosis is an antisocial personality, although caution should be made especially when categorizing adolescents since these scales are more commonly elevated for both normal and abnormal adolescents. If scale 8 is also high, it may reflect either a manic state or schizophrenia.

68/86

The key feature of people with the 68/86 code type is that they are suspicious and distrustful, often perceiving the intentions of others as suspect and questionable. They will be extremely distant from others with few or no friends. They can be described as inhibited, shy, resentful, anxious, and unable to accept or appropriately respond to the demands that are made of them. This is because they are highly involved in their fantasy world, uncooperative, and apathetic, and because they have poor judgment and experience difficulty concentrating. Their sense of reality is poor, and they often experience guilt, inferiority, and mental confusion although sometimes their affect will be flat. The content of their thoughts can be expected to be unusual if not bizarre, frequently containing delusions of grandeur and/or self-reference. Surprisingly, their past work history is often adequate, but an intensification of their symptoms brought on by stress will usually disrupt their ability to work. Persons with this code are more often single and younger than 26 years of age. If they are married, their spouses are frequently also emotionally disturbed.

The most frequent diagnosis is paranoid schizophrenia, especially if scale 4 is also elevated. These persons will experience depression, inappropriate affect, phobias, and paranoid delusions. If scale 7 is 10 points or more lower than scales 6 and 8, this pattern is referred to as the "paranoid valley" and emphasizes the presence of paranoid ideation. If F is highly elevated while scales 6 and 8 are above 80, this does not necessarily indicate an invalid profile. A paranoid state is also a frequent diagnosis with the 68/86 code; less frequently, organic brain disorders or severe anxiety disorders may be diagnosed.

78/87

The 78/87 code often occurs among psychiatric patients and reflects a level of agitation sufficiently intense to disrupt their daily activities. Usually this profile represents a reaction to a specific crisis. They may have been previously functioning at a fairly adequate level until some event or series of events triggered off a collapse in their defenses. Their style of relating to others is passive, and they have difficulty developing and sustaining mature heterosexual relationships. They are lacking in self-confidence, often experience insomnia, and may have hallucinations and delusions. Common feelings include guilt, inferiority, confusion, worry, and fear, and they may have difficulties related to sexual performance. There may be significant suicidal risk, which can be further evaluated by looking at the relative elevation of scale 2, checking relevant critical items, taking a careful history, and asking relevant questions related to their thought processes.

The extent of elevations on scales 7 and 8, and the relative heights between them, have important implications both diagnostically and prognostically. If scale 7 is higher than scale 8, the person's psychological condition is more susceptible to improvement and tends to be more benign. This has a tendency to be true regardless of the elevation of 8, so long as 7 maintains its relatively higher position. The higher scale 7 suggests that the person is still actively fighting his problem and has some of his defenses still working. Thus, engrained bizarre thought patterns and withdrawn behavior have not yet become established. A relatively higher scale 8, on the other hand, reflects more fixed patterns and is therefore more difficult to treat. This is particularly true if scale 8 is over 75. If scales 7 and 8 are both greater than 75 (with scale 8 relatively higher), this suggests an established schizophrenic pattern, especially if the "neurotic triad" is low. Even if schizophrenia can be ruled out, the condition tends to be extremely resistant to change, as for example, with a severe, alienated personality disorder. If scale 2 is also elevated, this raises the possibility of either a dysthymic or obsessive-compulsive disorder.

89/98

The 89/98 code suggests persons who are highly energetic, perhaps to the point of hyperactivity. They will be emotionally labile, tense, and disorganized, with the possibility of delusions of grandeur sometimes with a religious flavor, especially if scale 6 is also elevated. Their goals and expectations will be unrealistic; they often make extensive plans which are far beyond their means to accomplish. Thus, their aspirations will be significantly higher than their actual achievements. Usually, they will have significant complaints related to insomnia. Their interpersonal relationships are childish and immature, and they will usually be fearful, distrustful, irritable, and distractible. This likewise makes psychotherapeutic approaches to them extremely difficult. Furthermore, their level of insight is poor, they resist psychological interpretations of their behavior, and they cannot focus on any one area for any length of time.

The most frequent diagnosis is schizophrenia, possibly a schizoaffective disorder with manic states. If there are extensive delusions and hallucinations, antipsychotic medication may be indicated. Sometimes the relative elevation of F can be used as an index of the relative severity of the disorder.

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CHAPTER 10

COMPREHENSIVE NEUROPSYCHOLOGICAL ASSESSMENT BATTERIES

Gerald Goldstein

This chapter is the first of three covering the area of neuropsychological assessment. It will provide a general introduction to neuropsychological assessment and deal specifically with the extensive standard test batteries used with adults. Neuropsychological assessment is a relatively new term that has essentially replaced the older terms *testing for brain damage* or *testing for organicity*. Lezak (1983) indicates that these procedures are used for three purposes: diagnosis, provision of information important for patient care, and research. A significant component of the patient care function is rehabilitation planning and monitoring (Golden, 1978; Goldstein & Ruthven, 1983; Meier, Benton, & Diller, 1987). The focus of neuropsychological assessment has traditionally been on the brain-damaged patient, but there have been major extensions of the field to psychiatric disorders (Goldstein, 1986; Gruzelier & Flor-Henry, 1979; Yozawitz, 1986), functioning of normal individuals (Kimura & Durnford, 1974), and normal aging (Goldstein & Shelly, 1975; Reed & Reitan, 1963).

Perhaps the best definition of a neuropsychological test has been offered by Ralph Reitan, who describes it as a test that is sensitive to the condition of the brain. If performance on a test changes with a change in brain function, then the test is a neuropsychological test. However, it should be noted that comprehensive neuropsychological test batteries should contain not only neuropsychological tests. They should also contain some tests that are generally insensitive to brain dysfunction, primarily because such tests are often useful for providing a baseline against which extent of impairment associated with acquired brain damag can be measured. Most neuropsychological assessment methods are formal tests, but some work ha been done with rating scales and self-report measures Neuropsychological assessment is rarely conducte through a structured interview outside a test situatio

A comprehensive neuropsychological test battery i a procedure that assesses all the major functional are generally affected by structural brain damage. We u the term ideally because none of the standard, co monly available procedures entirely achieves fu comprehensiveness. Some observers have describ the comprehensive procedures as screening batteri because feasibility and time constraints general require a sacrifice of detailed investigations of speci areas in order to achieve comprehensiveness. In Ha sher's chapter (12), we will learn more about wha clinical neuropsychologist does when asked to expl a particular area in detail rather than do a comprehe sive evaluation. While the term *screening* may justifiable in certain respects, the extensive stand batteries in common use should not be grouped w the brief, paper-and-pencil screening tests used many clinical and industrial settings. That is, they not simply screen for presence or absence of br damage, but also evaluate a number of functio areas that may be affected by brain damage. Beca brain damage radically affects cognitive process most neuropsychological tests assess various area cognition, but perception and motor skills are frequently evaluated. Thus, neuropsychological t are generally thought of as assessment instruments a variety of cognitive, perceptual, and motor skills. That is not to say that brain damage does not affect other aspects of the personality, but traditionally the standard neuropsychological tests do not typically assess these other areas. Perhaps the most important reason for this preference is that cognitive tests have proven to be the most diagnostic ones. While personality changes may occur with a wide variety of psychiatric, general medical, and neurological conditions, cognitive changes appear to occur most dramatically in individuals with structural brain damage.

Numerous attempts have been made to classify the functional areas typically affected by brain damage, but the scheme proposed in what follows is a reasonably representative one. Perhaps the most ubiquitous change is general intellectual impairment. Following brain damage, the patient is not as bright as he or she was before. Problems are solved less effectively, goal-directed behavior becomes less well organized, and there is impairment of a number of specific skills such as solving arithmetic problems or interpreting proverbs. Numerous attempts have been made to epitomize this generalized loss, perhaps the most successful one being Goldstein and Scheerer's (1941) concept of impairment of the abstract attitude. The abstract attitude is essentially a phenomenological concept having to do with the way in which the individual perceives the world. Some consequences of its impairment involve failure to form concepts or to generalize from individual events, failure to plan ahead ideationally, and inability to transcend the immediate stimulus situation. While the loss is a general one involving many aspects of the individual's life, it is best observed in a testing setting where the patient is presented with a novel situation in which some problem must be solved. Typically these tests involve abstraction or concept formation, and the patient is asked to sort or categorize in some way. The Goldstein-Scheerer (1941) tests, perhaps the first neuropsychological battery, consist largely of sorting tests, but also provide the patient with other types of novel problem-solving tasks.

Probably the next most common manifestation of structural brain damage is impairment of memory. Sometimes memory impairment is associated with general intellectual impairment, sometimes it exists independently, and sometimes it is seen as an early sign of a progressive illness that eventually impairs a number of abilities other than memory. In most but not all cases, recent memory is more impaired than remote memory. That is, the patient may recall his or her early life in great detail, but may be unable to recall what happened during the previous day. Often, so-called primary memory is also relatively well preserved. That is, the patient may be able to repeat immediately what was just presented to him, such as a few words or a series of digits, but will not retain new information over a more extended period of time, particularly after intervening events have occured. In recent years, our capacity to examine memory has benefited from a great deal of research involving the various amnesic syndromes (e.g., Butters & Cermak, 1980; Squire, Slater, & Chace, 1975; Warrington & Weiskrantz, 1982), and we have become quite aware that not all brain-damaged patients experience the same kind of memory disorder (Butters, 1983). A detailed assessment is generally required to identify specifically the various types of memory disorder, and the comprehensive batteries we will be discussing here generally can detect only the presence of a memory disorder and provide an index of its severity.

Loss of speed in performing skilled activities is an extremely common symptom of brain damage. Generally, this loss is described in terms of impaired psychomotor speed or perceptual-motor coordination While its basis is sometimes reduction of pure motor speed, in many instances pure speed is preserved in the presence of substantial impairment on tasks involving speed of some mental operation or coordination of skilled movement with perceptual input. Thus, the patient may do well on a simple motor task, such as finger tapping, but poorly on a task in which movement must be coordinated with visual input, such as a cancellation or substitution task. Tasks of this latter type are commonly performed slowly and laboriously by many kinds of brain-damaged patients. Aside from slowness, there may be other disturbances of purposive movement that go under the general heading of apraxia. Apraxia may be manifested as simple clumsiness or awkwardness, an inability to carry out goal directed movement sequences as would be involved in such functional activities as dressing, or as an inability to use movement ideationally as in producing gestures or performing pretended movements. While apraxia in one of its pure forms is a relatively rare condition, impairment of psychomotor speed is quite common and seen in a variety of conditions.

A set of abilities that bridge movement and perception may be evaluated by tasks in which the patient must produce some form of construction or copy a figure from a model. Among the first tests used to test brain-damaged patients was the Bender-Gestalt (Bender, 1938), a procedure in which the patient must copy a series of figures devised by Wertheimer (1923) to study perception of visual gestalten. It was found that many patients had difficulty copying these figures, although they apparently preceived them normally. These difficulties manifested themselves in reasonably characteristic ways, including various forms of distortion, rotation of the figure, simplification, or primitivation and perseveration. The copying task has continued to be used by neuropsychologists, either in the form of the Bender-Gestalt or a variety of other procedures. Variations of the copying task procedure have involved having the patient draw the figure from memory (Benton, 1963; Rey, 1941), from a verbal command, for example, "Draw a Circle" (Luria, 1973), or copy a figure that is embedded in an interfering background pattern (Canter, 1970). Related to the copying task is the constructional task, in which the patient must produce a three-dimensional construction from a model. The most popular test for this purpose is the Kohs Blocks or Block Design subtest of the Wechsler Scales (Wechsler, 1955). While in the timed versions of these procedures the patient may simply fail the task by virtue of running out of time, at least some brain-damaged patients make errors on these procedures comparable to what is seen on the copying tasks. With regard to block design type tasks, the errors might involve breaking the contour of the model or incorrectly reproducing the internal structure of the pattern (Kaplan, 1979). Thus, a constructional deficit may not be primarily associated with reduction in psychomotor speed, but rather with the inability to build configurations in three-dimensional space. Often, this ability is referred to as visual-spatial skill.

Visual-spatial skills also form a bridge with visual perception. When one attempts to analyze the basis for a patient's difficulty with a constructional task, the task demands may be broken down into movement, visual, and integrative components. Often, the patient has no remarkable impairment of purposive, skilled movement and can recognize the figure. If it is nameable (the patient can tell you what it is) or if it is not, it can be correctly identified on a recognition task. However, the figure cannot be accurately copied.

While the difficulty may be with the integration between the visual percept and the movement, it has also been found that patients with constructional difficulties, and indeed patients with brain damage in general, frequently have difficulties with complex visual perception. For example, they do poorly at embedded figures tasks (Teuber, Battersby, & Bender, 1951) or at tasks in which a figure is made difficult to recognize through displaying it in some unusual manner, such as overlapping it with other figures (Golden, 1981b) or presenting it in some incomplete or ambiguous form (Mooney, 1957). Some brain-damaged patients also have difficult when the visual task is made increasingly comple through adding elements in the visual field. Thus, th patient may identify a single element, but not two When two stimuli are presented simultaneously, th characteristic error is that the patient reports seein only one. The phenomenon is known as extinctio (Bender, 1952) or neglect (Heilman, 1979).

Many brain-damaged patients also have deficits i the areas of auditory and tactile perception. Sometimes, the auditory impairment is such that the patien can hear, but sounds cannot be recognized or interpreted. The general condition is known as agnosia an can actually occur in the visual, auditory, or tactil modalities. Agnosia has been defined as "perceptio without meaning," implying the intactness of th primary sense modality but loss of the ability t comprehend the incoming information. Auditory agnosia is a relatively rare condition, but there are man disturbances of auditory perception that are commonly seen among brain-damaged patients. Auditor neglect can exist and is comparable to visual neglec sounds to either ear may be perceived normally, bu when a sound is presented to each ear simultaneousl only one of them may be perceived. There are number of auditory verbal problems that we wi examine in the discussion of language. Auditor attentional deficits are common and may be identifie by presenting complex auditory stimuli, such as rhyt mic patterns, which the patient must recognize reproduce immediately after presentation. A varie of normal and abnormal phenomena may be demo strated using a procedure called dichotic listeni (Kimura, 1961). It involves presenting two differe auditory stimuli simultaneously to each ear. Th subject wears earphones, and the stimuli are present using stereophonic tape. Higher-level tactile defic generally involve a disability with regard to identif ing symbols or objects by touch. Tactile neglect m be demonstrated by touching the patient over a seri of trials with single and double stimuli, and tact recognition deficits may be assessed by asking t patient to name objects placed in his or her hand or identify numbers or letters written on the surface of t skin. It is particularly difficult to separate prima sensory functions from higher cognitive processes the tactile modality, and many neuropsychologi perform rather detailed sensory examinations of t hands, involving such matters as light touch thres olds, two-point discrimination, point localization, a the ability to distinguish between sharp and dull tact stimuli (Semmes, Weinstein, Ghent, & Teub 1960).

The neuropsychological assessment of speech and language has in some respects become a separate discipline involving neuropsychologists, neurologists, and speech and language pathologists. There is an extensive interdisciplinary literature in the area (Albert, Goodglass, Helm, Rubens, & Alexander, 1981), and several journals that deal almost exclusively with the relationships between impaired or normal brain function and language (e.g., *Brain and Language*). Aphasia is the general term used to denote impairment of language abilities as a result of structural brain damage, but not all brain-damaged patients with communicative difficulties have aphasia. While aphasia is a general term covering numerous subcategories, it is now rather specifically defined as an impairment of communicative ability associated with focal damage to the hemisphere of the brain that is dominant for language—the left hemisphere in most people. Aphasia is generally produced as a result of disorders that have a sudden onset, notably stroke and head trauma, but it may sometimes be seen in cases of other localized diseases such as brain tumors and focal infections. Stroke is probably the most common cause of aphasia.

Historically, there have been numerous attempts to categorize the subtypes of aphasia (Goodglass, 1983), but in functional terms, the aphasias involve a rather dramatic impairment of the capacity to speak, to understand the speech of others, to find the names for common objects, to read (alexia), write (agraphia), calculate (acalculia), or to use or comprehend gestures. However, a clinically useful assessment of these functional disorders must go into their specific characteristics. For example, when we say the patient has lost the ability to speak, we may mean that he or she has become mute or can produce only a few utterances in a halting, labored way. On the other hand, we may mean that the patient can produce words fluently, but the words and sentences being uttered make no sense. When it is said that the patient does not understand language, that may mean that spoken but not written language is understood, or it may mean that all modalities of comprehension are impaired. Thus, there are several aphasic syndromes, and it is the specific syndrome that generally must be identified in order to provide some correlation with the underlying localization of the brain damage and to make rational treatment plans. We may note that the standard comprehensive neuropsychological test batteries do not include extensive aphasia examinations. There are several such examinations available, such as the Boston Diagnostic Aphasia Examination (Goodglass & Kaplan, 1983) and the Western Aphasia Battery (Kertesz, 1979). Even though they may be used in conjuction with a neuropsychological assessment battery, they are rather lengthy procedures in themselves and require special expertise to administer and interpret.

For various reasons, it is often useful to assess attention as part of the neuropsychological examination. Sometimes, an attention deficit is a cardinal symptom of the disorder, but even if it is not, the patient's level of attention may influence performance on tests of essentially all the functional areas we have been discussing. A discussion of attention may be aided by invoking a distinction between *wide aperture* and *narrow aperture* attention (Kinsbourne, 1980). Wide aperture attention has to do with the individual's capacity to attend to an array of stimuli at the same time. Attention may be so narrowly focused that the total picture is not appreciated. Tests for neglect may in fact be assessing wide aperture attention. Narrow aperture attention has to do with the capacity to sustain attention to small details. Thus, it can be assessed by vigilance tasks or tests like the Picture Completion subtest of the Wechsler scales. Brain-damaged patients may manifest attentional deficits of either type. They may fail to attend to a portion of their perceptual environment, or they may be unable to maintain sufficient concentration to complete successfully tasks requiring sustained occupation with details. Individuals with attentional deficits are often described as distractible or impulsive, and in fact, many brain-damaged patients may be accurately characterized by those terms. Thus, the assessment of presence and degree of attention deficit is often a highly clinically relevant activity. Recently, Mirsky (in press) has proposed a useful division, based upon a factor analytic study of attentional tasks, dividing them into tests that evaluate encoding, sustaining concentration, focusing, and shifting attention from one aspect of a task to another.

In summary, neuropsychological assessment typically involves the functional areas of general intellectual capacity, memory, speed and accuracy of psychomotor activity, visual-spatial skills, visual, auditory, and tactile perception, language, and attention. Thus, a comprehensive neuropsychological assessment may be defined as a procedure that surveys at least all of these areas. In practical terms, a survey is all that is feasible if the intent of the assessment is to evaluate all areas. It is obviously generally not feasible to do an indepth assessment of each of these areas in every patient, nor is it usually necessary to do so.

PROBLEMS IN CONSTRUCTION AND STANDARDIZATION OF TEST BATTERIES

It will be assumed here that neuropsychological tests share the same standardization requirements as all other psychological tests. That is, there is the need for appropriate quantification, norms, and related test construction considerations, as well as the need to deal with issues related to validity and reliability. However, there are some special considerations regarding neuropsychological tests, and we will turn our attention to them here.

Practical Concerns in Test Construction

Neuropsychological test batteries must of necessity be administered to brain-damaged patients, many of whom may have severe physical disability, cognitive impairment, or a combination of the two. Therefore, the stimulus and response characteristics of the tests themselves, as well as the stimulus characteristics of the test instructions, become exceedingly important considerations. Neuropsychological test materials should, in general, be constructed with salient stimuli that the patient can readily see or hear and understand. The material to be read should not require high levels of literacy, nor should the grammatical structures be unduly complex. With regard to test instructions, the potential for multimodal instruction giving should ideally be available. If the patient cannot see or read, it should be possible to give the instructions verbally, without jeopardizing the clinician's opportunity to use established test norms. The opportunity should be available to repeat and paraphrase instructions until it is clear that the patient understands them. It is of crucial importance in neuropsychological assessment that the examiner achieve maximum assurance that a test was failed because the patient could not perform the task being assessed, not because the test instructions were not understood. This consideration is of particular importance for the aphasic patient, who may have a profound impairment of language comprehension. With regard to response parameters, efforts should be made to assure that the test response modality is within the patient's repertoire.

In neuropsychological assessment, it is often not the failure to perform some specific task that is diagnostic, but the failure to perform some component of a series of tasks in the presence of intact function in other areas. As an example, failure to read a passage is not specifically diagnostic, because the inability to read may be associated with a variety of cognitive, perceptual, and learning difficulties. However, failure to be able to transfer a grapheme or a written symbol to a phoneme or sound in the presence of other manifestations of literacy could be quite diagnostic. Individuals with this type of deficit may be able to "sight-read" or recognize words as perceptual patterns, but when asked to read multisyllabic, unfamiliar words, they are unable to break the word down into phonemes and sound it out. In perhaps its most elegant form, neuropsychological assessment can produce what is called a double dissociation (Teuber, 1959): a task consistently failed by patients with a particular type of brain disorder accompanied by an equally difficult corresponding task that is consistently passed, and the reverse in the case of patients with some other form of brain disorder. Ideally, then, neuropsychological assessment aims at detailed as possible specification of what functional deficits exist in a manner that allows for mapping of these deficits onto known systems in the brain. There are several methods of achieving this goal, and not all neuropsychologists agree with regard to the most productive route. In general, some prefer to examine patients in what may be described as a linear manner, with a series of interlocking component abilities, while others prefer using more complex tasks in the form of standard, extensive batteries and interpretation through examination of performance configurations. The linear approach is best exemplified in the work of A. R. Luria (1973) and various collaborators, while the configural approach is seen in the work of Ward Halstead (1947), Ralph Reitan (Reitan & Davison, 1974), and their many collaborators. In either case, however, the aim of the assessment is largely that of determining the pattern of th· patient's preserved and impaired functions and inferring from this pattern what the nature might be of th disturbed brain function. The difficulty with usin complex tasks to achieve that end is that such tasks ar really only of neuropsychological interest if they ca be analyzed by one of the two methods described here

Issues Related to Validity and Reliability

Neuropsychological assessment has the advantag of being in an area where the potential for development of highly sophisticated validation criteria ha been very much realized in recent years and will sure achieve even fuller realization in the near future. We begin our discussion with this consideration, and are first occupied with the matters of concurrent and predictive validity. A major review of validation studies was accomplished by Klove (1974) and updated by Boll (1981). Reitan and Wolfson (1985) have written an entire volume on the Halstead-Reitan battery, which contains a brief review of pertinent research findings in addition to extensive descriptions of the tests themselves and case materials. These reviews essentially covered only the Wechsler scales and Halstead-Reitan Battery, but there are several reviews of the work with the Luria-Nebraska Neuropsychological Battery as well (e.g., Golden, 1981b). We will not deal with the content of those reviews at this point, but rather focus on the methodological problems involved in establishing concurrent or predictive validity of neuropsychological tests. With regard to concurrent validity, the criterion used in most cases is the objective identification of some central nervous system lesion arrived at independently of the neuropsychological test results. Therefore, validation is generally provided by neurologists or neurosurgeons. Identification of lesions of the brain is particularly problematic because, unlike many organs of the body, the brain cannot usually be visualized directly in the living individual. The major exceptions occur when the patient undergoes brain surgery or receives the rarely used procedure of brain biopsy. In the absence of these procedures, validation is dependent upon autopsy data or the various brain imaging techniques. Autopsy data are not always entirely usable for validation purposes, in that numerous changes may have taken place in the patient's brain between time of testing and time of examination of the brain. Of the various imaging techniques, the CT scan is currently the most fruitful one. Cooperation among neuroradiologists, neurologists, and neuropsychologists has already led to the accomplishment of several important studies correlating quantitative CT scan data with neuropsychological test results (e.g., Hill & Mikhael, 1979). Beyond the CT scan, however, we can see the beginnings of even more sensitive indicators, including measures of cerebral metabolism such as the PET scan (Positron Emission Tomography), the Xenon enhanced CT scan, and the advanced imaging techniques that may develop from the new method of nuclear magnetic resonance (NMR). Recently, more generally available and even more sensitive measures of cerebral metabolism have appeared, including generations of the PET scan allowing for greatly improved resolution SPECT (Single Photon Emission Computerized Tomography) which allows for studying brain metabolism in settings in which a cyclotron is not available, and the evolving method of magnetic resonance imaging spectroscopy. These exciting new developments in brain imaging and observation of brain function will surely provide increasingly definitive criteria for neuropsychological hypotheses and assessment methods.

Within neuropsychological assessment, there appears to have been a progression regarding the relationship between level of inference and criterion. Early studies in the field as well as the development of new assessment batteries generally addressed themselves to the matter of simple presence or absence of structural brain damage. Thus, the first question raised had to do with the accuracy with which an assessment procedure could discriminate between brain-damaged and non-brain-damaged patients, as independently classified by the criterion procedure. In the early studies, the criterion utilized was generally clinical diagnosis, perhaps supported in some cases by neurosurgical data or some laboratory procedure such as a skull X-ray or an EEG. It soon became apparent, however, that many neuropsychological tests were performed at abnormal levels, not only by brain-damaged patients, but by patients with several of the functional psychiatric disorders. Because many neuropsychologists worked in neuropsychiatric rather than general medical settings, this matter became particularly problematic. Great efforts were then made to find tests that could discriminate between brain-damaged and psychiatric patients or, as sometimes put, between "functional" and "organic" conditions. There have been several reviews of this research (Goldstein, 1978; Heaton, Baade, & Johnson, 1978; Heaton & Crowley, 1981; Malec, 1978), all of which were critical of the early work in this field in light of current knowledge about several of the functional psychiatric disorders. The chronic schizophrenic patient was particularly problematic, because such patients often performed on neuropsychological tests in a manner indistinguishable from the performance of patients with generalized structural brain damage. By now, this whole issue has been largley reformulated in terms of looking at the neuropsychological aspects of many of the functional psychiatric disorders (e.g., Gruzelier & Flor-Henry, 1979; Henn & Nasrallah, 1982), largely under the influence of the newer biological approaches to psychopathology.

Neuropsychologists working in neurological and neurosurgical settings were becoming increasingly interested in validating their procedures against more refined criteria, notably in the direction of localization of brain function. The question was no longer only whether a lesion was present or absent, but if present, whether the tests could predict its location. Major basic research regarding this matter was conducted by H.-L. Teuber and various collaborators over a span of many years (Teuber, 1959). This group had access to a large number of veterans who had sustained open head injuries during World War II and the Korean conflict. Because the extent and site of their injuries were exceptionally well documented by neurosurgical and radiological data, and the lesions were reasonably well localized, these individuals were used productively in a long series of studies in which attempts were made to relate both site of lesion and concomitant neurological defects to performance on an extensive series of neuropsychological procedures ranging from measures of basic sensory functions (Semmes, Weinstein, Ghent, & Teuber, 1960) to complex cognitive skills (Teuber & Weinstein, 1954). Similar work with brain-wounded individuals was accomplished by Freda Newcombe and collaborators at Oxford (Newcombe, 1969). These groups tended to concentrate on the major lobes of the brain (frontal, temporal, parietal, and occipital), and would, for example, do contrasts between the performances of patients with frontal and occipital lesions on some particular test or test series (e.g., Teuber, 1964). In another setting, but at about the same time the Teuber group was beginning its work, Ward Halstead (1947) and collaborators conducted a large-scale neuropsychologically oriented study of frontal lobe function. Ralph M. Reitan, who was Halstead's student, adopted several of his procedures, supplemented them, and developed a battery of tests that were extensively utilized in localization studies. Reitan's (1955) early work in the localization area was concerned with differences between the two cerebral hemispheres more than with regional localization. The now well-known Wechsler-Bellevue studies of brain lesion lateralization (see review in Reitan, 1966) represented some of the beginnings of this work. The extensive work of Roger Sperry and various collaborators (Sperry, Gazzaniga, & Bogen, 1969) with patients who had undergone cerebral commisurotomy also contributed greatly to validation of neuropsychological tests with regard to the matter of differences between the two hemispheres, particularly the functional asymmetries or cognitive differences. Since the discoveries regarding the major roles of subcortical structures in the mediation of various behaviors (Albert, 1978), neuropsychologists have also been studying the relationships betweeen test performance an lesions in such structures and structure complexes a the limbic system (Scoville & Milner, 1957) and th basal ganglia (Butters, 1983).

The search for validity criteria has become increas ingly precise with recent advances in the neuro sciences as well as increasing opportunities to collec test data from various patient groups. One majo conceptualization largely attributable to Reitan an his co-workers is that localization does not alway operate independently with regard to determination o behavioral change, but interacts with type of lesion o the specific process that produced the brain damage The first report regarding this matter related to differ ences in performance between patients with recentl acquired lateralized brain damage and those who ha sustained lateralized brain damage at some time in the remote past (Fitzhugh, Fitzhugh, & Reitan, 1961 1962). Patients with acute lesions were found t perform differently on tests from patients with chroni lesions. It soon became apparent, through an ex tremely large number of studies (cf. Filskov & Boll 1981) that there are many forms of type-locus interac tions, and that level and pattern of performance o neuropsychological tests may vary greatly with the particular nature of the brain disorder. This develop ment paralleled such advances in the neurosciences a the discovery of neurotransmitters and the relationshi between neurochemical abnormalities and a numbe of the neurological disorders that historically had bee of unknown etiology. We therefore have the begin nings of the development of certain neurochemica validating criteria (Davis, 1983). There has also bee increasing evidence for a genetic basis for severa mental and neurological disorders. The gene for Hun tington's disease is close to being discovered, an there is growing evidence of a significant geneti factor contributing to the acquisition of certain form of alcoholism (Steinhauer, Hill, & Zubin, 1987). I general, the concurrent validity studies have bee quite satisfactory, and many neuropsychological tes procedures have been shown to be accurate indicator of many parameters of brain dysfunction.

A persistent problem in the past has been th possible tendency of neuropsychological tests to b more sensitive than the criterion measures. In fact, study by Filskov and Goldstein (1974) demonstrate that neuropsychological tests may predict diagnosi more accurately than many of the individual neurodi agnostic procedures commonly used in assessment o neurological and neurosurgical patients (e.g., skul X-ray). It would appear that with the advent of the C scan and the even more advanced brain imaging procedures, this problem will be diminishing. A related problem involves the establishment of the most accurate and reliable external criterion. We have always taken the position (Goldstein & Shelly, 1982; Russell, Neuringer, & Goldstein, 1970) that no one method can be superior in all cases, and that the best criterion is generally the final medical opinion based on a comprehensive but pertinent evaluation, excluding, of course, behavioral data. In some cases, for example, the CT scan may be relatively noncontributory, but there may be definitive laboratory findings based on examination of blood or cerebral spinal fluid. In some cases (e.g., Huntington's disease) the family history may be the most crucial part of the evaluation. It is not being maintained here that the best criterion is a doctor's opinion, but rather that no single method can stand out as superior in all cases when one is dealing with a variety of disorders. The diagnosis is often best established through the integration by an informed individual of data coming from a number of sources. A final problem to be mentioned here is that objective criteria do not yet exist for a number of neurological disorders, but even this problem appears to be undergoing a rapid stage of solution. Most notable in this regard is the in vivo differential diagnosis of the degenerative diseases of old age, such as Alzheimer's disease. There is also no objective laboratory marker for multiple sclerosis, and diagnosis of that disorder continues to be made on a clinical basis. Only advances in the neurosciences will lead to ultimate solutions to problems of this type.

In clinical neuropsychology, predictive validity has mainly to do with course of illness. Will the patient get better, stay the same, or deteriorate? Generally, the best way to answer questions of this type is through longitudinal studies, but very few such studies have actually been done. Even in the area of normal aging, in which many longitudinal studies have been accomplished, there really have been no extensive neuropsychologically oriented longitudinal studies. There is, however, some literature on recovery from stroke, much of which is attributable to the work of Meier and collaborators (Meier, 1974). Levin, Benton, and Grossman (1982) provide a discussion of recovery from closed head injury. Of course, it is generally not possible to do a full neuropsychological assessment immediately following closed head injury, and so prognostic instruments used at that time must be relatively simple ones. In this regard, a procedure known as the Glasgow Coma Scale (Teasdale & Jennett, 1974) has well-established predictive validity. Perhaps one of the most extensive efforts directed toward establishment of the predictive validity of neuropsychological tests was accomplished by Paul Satz and various collaborators, involving the prediction of reading achievement in grade school based on neuropsychological assessments accomplished during kindergarten (Fletcher & Satz, 1980; Satz, Taylor, Friel, & Fletcher, 1978). At the other end of the age spectrum, there are currently several ongoing longitudinal studies contrasting normal elderly individuals with dementia patients (Danziger, 1983; Wilson & Kaszniak, 1983). However, we do not yet know from these studies and other ongoing longitudinal investigations what the best prognostic instruments are for predicting the course of dementia or for determining whether or not an elderly individual suspected of having dementia will deteriorate or not.

An important aspect of predictive validity has to do with prediction of treatment and rehabilitation outcome. Ben-Yishay, Gerstman, Diller, and Haas (1970) were able to show that a battery of neuropsychological tests could successfully predict length of time in rehabilitation and functional outcome in patients with hemiplegia. There have been several studies (reviewed by Parsons & Farr, 1981) concerned with predicting outcome of alcoholism treatment on the basis of neuropsychological test performance. The results of these studies are mixed, but in general it would appear that test performance during the early stages of treatment may bear some relationship to outcome as evaluated by followup. Before leaving this area, I should mention that there are several not fully documented but apparently reasonable clinical principles related to prediction of treatment outcome. In general, patients with relatively well-circumscribed deficits and perhaps underlying structural lesions, tend to do better in treatment than do patients with more global deficits. Some data suggest that early intervention for aphasic adults, perhaps within two months post-onset, is more effective than treatment initiated later (Wertz, 1983). Ben-Yishay, Diller, Gerstman, and Gordon (1970) have suggested that an individual's level of competence on a task to be trained is related to his or her ability to profit from cues utilized in the training procedure.

In general, studies of predictive validity in neuropsychological assessment have not been as extensive as studies involving concurrent validity. However, the data available suggest that neuropsychological tests can predict degree of recovery or deterioration to some extent and have some capacity to predict treatment outcome. Because many neurological disorders change over time, getting better or worse, and the treatment of neurological disorders is becomimg an increasingly active field (Reisberg, Ferris, & Gershon, 1980), it is often important to have some foreknowledge of what will happen to the patient in the future in a specific rather than general way and to determine whether the patient is a good candidate for some form of treatment. Efforts have also been made to predict functional abilities involved in personal self-care and independent living on the basis of neuropsychological test performance, particularly in the case of elderly individuals (McCue, Rogers, Goldstein, & Shelly, 1987). The extent to which neuropsychological assessment can provide this prognostic information will surely be associated with the degree of its acceptance in clinical settings.

Studies of the construct validity of neuropsychological tests represent a great amount of the corpus of basic clinical neuropsychological research. Neuropsychology abounds with constructs: short-term memory, attention, visual-spatial skills, psychomotor speed, motor engrams, and cell-assemblies. Tests are commonly characterized by the construct they purport to measure; Test A is one of long-term memory; Test B is one of attention; Test C is one of abstraction ability; Test D is a measure of biological intelligence, etc. Sometimes we fail to recognize constructs as such because they are so well established, but concepts like memory, intelligence, and attention are in fact theoretical entities used to describe certain classes of observable behaviors. Within neuropsychology, the process of construct validation generally begins with an attempt to find a measure that evaluates some concept. Let us begin with a simple example, say the desire to develop a test for memory. Memory, as a neuropsychological construct, would involve a brain-behavior relationship. That is, neuropsychologists are concerned with how the brain mediates memory and with how impaired brain function affects memory. There are memory tests available, notably the newly revised Wechsler Memory Scale (WMS-R) (Wechsler, 1987), but without experimental studies, that scale would have only face validity. That is, it appears to be a test of memory on the basis of the nature of the test items. However, if we ask the related question, "Does the patient who does well on the scale have a normal memory?" we would have to know more about the test in regard to how well it assesses memory as a construct. Reasonable alternative hypotheses might be that the scale measures intelligence, educational level, or attention, or that these influences confound the test such that impairment of memory per se cannot be unequivocally identified.

The problem may be approached in numerous subtests of the Wechsler Memory Scale are placed into a factor analysis along with educational level and tests of intelligence and attention. It may be found that the memory scale subtests load on their own factor or on factors that receive high loadings from the intelligence and attention tests or from educational level. Another approach may involve giving the test to patients with amnesia and to nonamnesic brain-damaged patients. A more sophisticated study may involve administering the Wechsler Memory Scale to these subjects along with other tests. Studies such as these may reveal some of the following hypothetical findings. The Wechsler Memory Scale is highly correlated with IQ, and so it is not possible to tell whether the scale measures the construct memory specifically or intellectual ability. Some patients cannot repeat stories read to them because they are aphasic and cannot produce words, not because of poor memories. Therefore, interpretation of the measure as an indicator of memory ability cannot be made unequivocally in certain populations. Certain amnesic patients do exceedingly poorly on certain components of the Wechsler Memory Scale, but well on other components. Such a finding would suggest that memory, as a neuropsychological construct, requires further refinement, because there appears to be a dissociation in patients known to have profound loss of memory between certain memory skills that are intact and others that are severely impaired. Still another approach, suggested by Cronbach (1960), is correlation with practical criteria. Individuals given the Wechsler Memory Scale could be asked to perform a number of tasks, all of which involve practical memory in some way, and the obtained data could be analyzed in terms of what parts of the scale predict success or failure at the various tasks.

Another important way of establishing the construct validity of neuropsychological test batteries involves determining capacity to classify cases into meaningful subtypes. In recent years, several groups of investigators have utilized classification statistics, notably R-type factor analysis and cluster analysis, in order to determine whether combinations of test scores from particular batteries classify cases in accordance with established diagnostic categories or into types that are meaningful from the standpoint of neuropsychological considerations. A great deal of effort has gone into establishing meaningful, empirically derived subtypes of learning disability (Rourke, 1985), and there has also been work done in the neuropsychologically based empirical classification of neuropsychiatric patients (Goldstein & Shelly, 1987; Goldstein, Shelly

It is particularly important to note that, at least in recent years, the construct validation of neuropsychological tests has involved a multidisciplinary effort with colleagues in cognitive psychology, the experimental psychology of memory and learning (utilizing both human studies and animal models), linguistics, and sensory and perceptual processes. For example, aphasia testing has been profoundly influenced by basic research in psycholinguistics (Blumstein, 1981), while memory testing has been correspondingly influenced by recent developments in information theory and the experimental psychology of memory and learning (Butters & Cermak, 1980; Squire & Butters, 1984). These experimental foundations have aided significantly in the interpretation of clinical tests, and indeed, many new clinical tests are actually derived from laboratory procedures.

While neuropsychological tests should ideally have reliability levels commensurate with other areas of psychometrics, there are some relatively unique problems. These problems are particularly acute when the test-retest method is used to determine the reliability coefficients. The basic problem is that this method really assumes the stability of the subject over testing occasions. When reliability coefficients are established through the retesting of adults over a relatively brief time period, that assumption is a reasonable one, but it is not as reasonable in samples of brain-damaged patients who may be rapidly deteriorating or recovering. Indeed, it is generally thought to be an asset when a test reflects the appropriate changes. Another difficulty with the test-retest method is that many neuropsychological tests are not really repeatable because of substantial practice effects. The split-half method is seldom applicable because most neuropsychological tests do not consist of lengthy lists of items, readily allowing for odd-even or other split-half comparisons. In the light of these difficulties, the admittedly small number of reliability studies done with the standard neuropsychological tests batteries have yielded perhaps surprisingly good results. Boll (1981) has reviewed reliability studies done with the Halstead-Reitan Battery; the test manual for the Luria-Nebraska Battery (Golden, Hammeke, & Purisch, 1980) reports reliability data for that instrument. The details of these matters are discussed later in our reviews of these two procedures. In any event, it seems safe to say that most neuropsychological test developers have not been greatly preoccupied with the reliabilities of their procedures, but those who have studied the matter appear to have provided sufficient data to permit the conclusion that the standard, commonly used procedures are at least not so unreliable as to impair the validities of those procedures.

AN INTRODUCTION TO THE COMPREHENSIVE BATTERIES

The number of generally available comprehensive standard neuropsychological test bateries for adults is not entirely clear. *The Handbook of Clinical Neuropsychology* (Filskov & Boll, 1981) contains chapters on only two batteries: the Halstead-Reitan and Luria-Nebraska. Lezak (1983) lists the Halstead-Reitan, the Smith Neuropsychological Battery, and two versions of batteries derived from Luria's work—one by Christensen (1975a, 1975b, 1975c), and Golden, Hammeke, and Purisch's Luria-Nebraska (originally South Dakota) Battery (1980). Jones and Butters (1983) reviewed the Halstead-Reitan, Luria-Nebraska, and Michigan batteries. Benton, Hamsher, Varney, and Spreen (1983) have produced a manual containing descriptions and instructions for tests these neuropsychologists have been associated with over the years, but there was clearly no intention to present this collection of tests as a standard battery. In this chapter, we will consider only the Halstead-Reitan and Luria-Nebraska procedures. The Michigan Battery (Smith, 1975) will not be reviewed, primarily because it consists largely of a series of standardized tests, all of which have their own validity and reliability literature. This literature is thoroughly reviewed by Lezak (1983).

The Halstead-Reitan Battery

History

The history of this procedure and its founders has been reviewed by Reed (1983). He traces the beginnings of the battery to the special laboratory established by Halstead in 1935 for the study of neurosurgical patients. The first major report on the findings of this laboratory appeared in a book called *Brain and Intelligence: A Quantitative Study of the Frontal Lobes* (Halstead, 1947), the title of which suggests that the original intent of Halstead's tests was to describe frontal lobe function. In this book, Halstead proposed his theory of "biological intelligence" and presented what was probably the first factor analysis done with neuropsychological test data. It is perhaps more significant that the book provides descriptions of many of the tests now contained in the Halstead-Reitan battery. As Reed (1983) suggests, the theory of biological intelligence was never widely accepted among neuropsychologists, and the factor analysis had its mathematical problems. But several of the tests that went into that analysis survived, and many of them are commonly used at present. In historical perspective, Halstead's major contributions to neuropsychological assessment, in addition to his very useful tests, include the concept of the neuropsychological laboratory in which objective tests are administered in standard fashions and quantitatively scored, and the concept of the impairment index, a global rating of severity of impairment and probability of the presence of structural brain damage.

Ralph M. Reitan was a student of Halstead at Chicago and was strongly influenced by his theories and methods. Reitan adopted the methods in the form of the various test procedures and with them established a laboratory at the University of Indiana. He supplemented these tests with a number of additional procedures in order to obtain greater comprehensiveness, and he initiated a clinical research program that is ongoing. The program began with a cross-validation of the battery and went on into numerous areas, including validation of new tests added to the battery (e.g., the Trail Making test), lateralization and localization of function, aging, and neuropsychological aspects of a wide variety of disorders such as alcoholism, hypertension, disorders of children, and mental retardation. Theoretical matters were also considered. Some of the major contributions included the concept of type-locus interaction (Reitan, 1966), the analysis of quantitative as opposed to qualitative deficits associated with brain dysfunction (Reitan, 1958, 1959), the concept of the brain-age quotient (Reitan, 1973), and the scheme for levels and types of inference in interpretation of neuropsychological test data (Reitan & Davison, 1974). In addition to the published research, Reitan and his collaborators developed a highly sophisticated method of blind clinical interpretation of the Halstead-Reitan Battery that continues to be taught at workshops conducted by Dr. Reitan and associates. The Halstead-Reitan Battery, as the procedure came to be known over the years, also has a history. It has been described as a "fixed battery," but that is not actually the case. Lezak (1976) says in reference to this development, "This set of tests has grown by accretion and revision and continues to be revised" (p. 440). Halstead's original battery, on which the factor analyses were based, included the Carl Hollow Square test, the Dynamic Visual Field Test, the Henmon-Nelson tests of mental ability, a flicker fusion procedure, and the Time Sense although the Time Sense and Flicker Fusion tests were originally included in the battery used by Reitan. The tests that survived include the Category test, the Tactual Performance test, the Speech Perception test, and Finger Tapping. Halstead also used the Seashore Rhythm test, which is included in the current version of the battery, but was not included in the sub-battery used by Halstead in his factor analyses. There have been numerous additions, including the various Wechsler Intelligence Scales, the Trail Making test, a sub-battery of perceptual tests, the Reitan Aphasia Screening test, the Klove Grooved Pegboard, and other tests that are used in some laboratories but not in others. Alternative methods have also been developed for computing the impairment index (Russell, Neuringer, & Goldstein, 1970).

Bringing this brief history into the present, the Halstead-Reitan Battery continues to be widely used as a clinical and research procedure. Numerous investigators utilize it in their research, and there have been several successful cross-validations done in settings other than Reitan's laboratory (Goldstein & Shelly, 1972; Vega & Parsons, 1967). In addition to the continuation of factor analytic work with the battery, several investigators have applied other forms of multivariate analysis to it in various research applications. Several investigations have been conducted relative to objectifying and even computerizing interpretation of the battery, the most well-known efforts probably being the Selz-Reitan rules for classification of brain function in older children (Selz & Reitan, 1979) and the Russell, Neuringer, and Goldstein "Neuropsychological Keys" (Russell et al., 1970). The issue of reliability of the battery has recently been addressed, with reasonably successful results. Clinical interpretation of the battery continues to be taught at workshops and in numerous programs engaged in training of professional psychologists. The most detailed description of the battery available will be found in Reitan and Wolfson (1985).

Structure and Content

Although there are several versions of the Halstead-Reitan Battery, the differences tend to be minor, and there appears to be a core set of procedures that essentially all versions of the battery contain. The battery must be administered in a laboratory containing a number of items of equipment and generally cannot be completely administered at bedside. Various estimates of length of administration are given, but it is probably best to plan on about 6 to 8 hours o patient time. Each test of the battery is independen and may be administered separately from the othe tests. However, it is generally assumed that a certain number of the tests must be administered in order to compute an impairment index.

Scoring for the Halstead-Reitan varies with the particular test, such that individual scores may be expressed in time to completion, errors, number correct, or some form of derived score. For research purposes, these scores are generally converted to standard scores so that they may be profiled. Matthews (1981) routinely uses a T-score profile in clinical practice, while Russell et al. (1970) rate all the tests contributing to the impairment index on a six-point scale, the data being displayed as a profile of the ratings. In their system the impairment index may be computed by calculating the proportion of tests performed in the brain-damaged range according to published cutoff scores (Reitan, 1955) or by calculating the average of the ratings. This latter procedure provides a value called the Average Impairment Rating. Russell et al. (1970) have also provided quantitative scoring systems for the Reitan Aphasia Screening test and for the drawing of a Greek cross that is part of that test. However, some clinicians do not quantify those procedures, except in the form of counting the number of aphasic symptoms elicited. We will return to other aspects of the battery's structure after the following description of the component tests.

A. Halstead's Biological Intelligence Tests

1. *The Halstead Category Test*: This test is a concept identification procedure in which the subject must discover the concept or principle that governs various series of geometric forms, verbal, and numerical material. The apparatus for the test includes a display screen with four horizontally arranged numbered switches placed beneath it. The stimuli are on slides, and the examiner uses a control console to administer the procedure. The subject is asked to press the switch that the picture reminds him or her of, and is provided with additional instructions to the effect that the point of the test is to see how well he or she can learn the concept, idea, or principle that connect the pictures. If the correct switch is pressed, the subject will hear a pleasant chime, while wrong answers are associated with a rasping buzzer. The conventionally used score is the total number of errors for the seven groups of stimuli that form the test. Booklet (Adams & Trenton, 1981; DeFillippis, McCampbell, & Rogers, 1979) and abbreviated forms (Calsyn et al., 1980; Russell & Levy, 1987; Sherrill, 1987) of this test have been developed.
2. *The Halstead Tactual Performance Test*: This procedure utilizes a version of the Seguin-Goddard Formboard, but it is done blindfolded. The subject's task is to place all of the 10 blocks into the board, using only the sense of touch. The task is repeated three times, once with the preferred hand, once with the nonpreferred hand and once with both hands, following which the board is removed. After removing the blindfold, the subject is asked to draw a picture of the board, filling in all of the blocks he or she remembers in their proper locations on the board. Scores from this test include time to complete the task for each of the three trials, total time, number of blocks correctly drawn, and number of blocks correctly drawn in their proper locations on the board.
3. *The Speech Perception Test*: The subject is asked to listen to a series of 60 sounds, each of which consist of a double e digraph with varying prefixes and suffixes (e.g., geend). The test is given in a four-alternative multiple-choice format, the task being to underline on an answer sheet the sound heard. The score is number of errors.
4. *The Seashore Rhythm Test*: This test consists of 30 pairs of rhythmic patterns. The task is to judge whether the two members of each pair are the same as or different from each other and to record the response by writing an S or a D on an answer sheet. The score is either number correct or number of errors.
5. *Finger Tapping*: The subject is asked to tap his or her extended index finger on a typewriter key attached to a mechanical counter. Several series of 10-second trials are run with both the right and the left hand. The scores are average number of taps, generally over five trials, for the right and left hand.

B. Tests Added to the Battery by Reitan

1. *The Wechsler Intelligence Scales*: Some clinicians continue to use the Wechsler-Bellevue, some the WAIS, and some the WAIS-R. In any event, the test is given according to manual instructions and is not modified in any way.
2. *The Trail Making Test*: In Part A of this procedure the subject must connect in order a series of circled numbers randomly scattered over a sheet of 8½ × 11 paper. In part B, there are circled numbers and letters, and the subject's task involves alternating between numbers and letters in serial order (e.g., 1 to A to 2 to B, etc.). The score is time to completion expressed in seconds for each part.

3. *The Reitan Aphasia Screening Test*: This test serves two purposes in that it contains both copying and language-related tasks. As an aphasia screening procedure, it provides a brief survey of the major language functions: naming, repetition, spelling, reading, writing, calculation, narrative speech, and right-left orientation. The copying tasks involve having the subject copy a square, Greek cross, triangle, and key. The first three items must each be drawn in one continuous line. The language section may be scored by listing the number of aphasic symptoms or by using the Russell et al. quantitative system. The drawings are not formally scored or are rated through a matching to model system also provided by Russell et al. (1970).
4. *Perceptual Disorders*: These procedures actually constitute a sub-battery and include tests of the subject's ability to recognize shapes and identify numbers written on the fingertips, as well as tests of finger discrimination and visual, auditory, and tactile neglect. Number of errors is the score for all of these procedures.

C. Tests Added to the Battery by Others

1. *The Klove Grooved Pegboard Test*: The subject must place pegs shaped like keys into a board containing recesses that are oriented in randomly varying directions. The test is administered twice, once with the right and once with the left hand. Scores are time to completion in seconds for each hand and errors for each hand, defined as number of pegs dropped during performance of the task.
2. *The Klove Roughness Discrimination Test*: The subject must order four blocks, covered with varying grades of sandpaper and presented behind a blind, with regard to degree of roughness. Time and error scores are recorded for each hand.
3. *Visual Field Examination*: Russell et al. (1970) include a formal visual field examination utilizing a perimeter as part of their assessment procedure. It should be noted that many clinicians, including Reitan and his collaborators, frequently administer a number of additional tests mainly for purposes of assessing personality and level of academic achievement. The MMPI is the major personality assessment method used, and achievement may be assessed with such procedures as the Wide Range Achievement Test-R (Jastak & Wilkinson, 1984) or the Peabody Individual Achievement Test (Dunn & Markwardt, 1970). Some clinicians have added the Wechsler Memory Scale (WMS or WMS-R) to the battery, either in its original form (Wechsler, 1945, 1987) or the Russell modification (Russell, 1975a). Some form of lateral dominance examination is also generally administered, including tests for handedness, footedness, and eyedness.

Quantitative Structural Considerations

Factor analysis is probably the clearest way of providing a quantitative description of the structure of a test battery. Many such analyses have been accomplished with the Halstead and Halstead-Reitan Battery, going back to Halstead's (1947) original work. Unfortunately, it is exceedingly difficult to compare one factor analytic study with another, largely because the battery has not remained stable over the years. For example, Halstead's original factor analysis involved the Flicker Fusion and Dynamic Visual Field tests, procedures that are rarely if ever used in current versions of the battery. Similarly, more recent factor analytic studies (Newby, Hallenbeck, & Embretson, 1983; Swiercinsky, 1979) utilized the Wechsler Memory Scale and other procedures that Halstead did not use, nor do many users of the battery. We will therefore take the solution of using some of our own factor analytic work (Goldstein & Shelly, 1971, 1972) as illustrative of the results one might achieve using a reasonably stripped down, core battery involving only Halstead's original tests that remain in common use, the WAIS, and the other procedures added to the battery by Reitan. The first of the two analyses utilized a sample of 50 alcoholic inpatients, while the second utilized a sample of 619 neuropsychiatric inpatients with miscellaneous diagnoses. The rotated factor matrices, presented in Table 10.1, are similar in some respects and dissimilar in others.

In both cases, the WAIS verbal subtests in combination with the aphasia screening test form a grouping (Factor 1) that clearly taps language abilities. There is a second factor largely contributed to by the WAIS performance tests, the Category test, and the speed component of the Tactual Performance test. The Finger Tapping test shows a different pattern in the two studies. In the analysis involving only the alcoholic patients, it loads on a factor along with several other tests, including WAIS Digit Symbol and the Seashore Rhythm test. In the case of the larger, more miscellaneous sample, Finger Tapping essentially achieves simple structure, forming its own factor. Thus, what the two factor analyses have in common are a verbal and a complex problem-solving factor. In the case of the alcoholic sample, there are three other

Table 10.1. Two Factor Analyses of the Halstead-Reitan Battery

	ROTATED FACTOR LOADINGS FOR ALCOHOLIC GROUP					ROTATED FACTOR LOADINGS FOR GENERAL PSYCHIATRIC GROUP			
TEST	1	2	3	4	5	1	2	3	4
WAIS Information	.87	.14	−.05	−.04	.06	.81	.20	−.04	.00
WAIS Comprehension	.70	.08	.14	.09	.05	.72	.22	.03	.04
WAIS Similarities	.69	.11	.11	.19	.08	.73	.25	.07	.06
WAIS Vocabulary	.84	−.05	.19	−.02	.20	.88	.12	−.02	.04
WAIS Picture Completion	.68	.37	.30	.22	.02	.52	.56	.18	.14
Aphasia Screening	.51	−.12	.15	.25	.17	.68	.21	.27	.08
WAIS Block Design	.03	.50	.39	.30	.20	.40	.62	.30	.15
WAIS Object Assembly	.13	.82	.41	.05	.16	.29	.63	.27	.11
Perceptual Disorders	.19	.61	.33	.16	.27				
Finger Agnosia—R						.20	.15	.64	.14
Finger Agnosia—L						.14	.24	.66	.09
Finger Writing—R						.07	.32	.60	.17
Finger Writing—L						−.01	.31	.60	.10
Halstead Category	.09	.68	−.03	.10	.25	.38	.55	.34	.07
Trail Making	.04	.64	.44	.17	.18	.42	.51	.32	.11
Tactual Performance Test—Time	−.02	.55	.36	.40	.08	.10	.69	.27	.20
WAIS Digit Symbol	.19	.18	.67	.22	.15	.41	.53	.32	.29
WAIS Picture Arrangement	.33	.25	.52	.11	−.03	.44	.60	.21	.12
Speech Perception	.38	.21	.51	−.11	−.03	.59	.24	.34	.19
Finger Tapping—DH	.06	.14	.71	.15	−.10	.08	.16	.20	.92
Finger Tapping—NDH						.10	.22	.17	.62
Seashore Rhythm	.10	.17	.69	.12	.20	.41	.24	.27	.13
Tactual Performance Test—Memory	.33	.38	.12	.79	−.15	.24	.65	.20	.14
Tactual Performance Test—Location	.09	.14	.20	.61	.04	.21	.60	.16	.07
WAIS Arithmetic	.20	.33	−.02	.07	.63	.64	.30	.23	.02
WAIS Digit Span	.38	.13	.24	−.18	.50	.57	.20	.20	.14
% of Original Variance Explained	18.26	14.86	14.23	7.72	5.03	22.29	17.41	10.75	6.50

Note. Some of the scores have been reflected so that higher scores always indicate above average performance.

perceptual and motor skills, one that receives salient loadings only from the memory and location components of the Tactual Performance Test, and one that receives loadings from the two WAIS numerical tests, Arithmetic and Digit Span. There was a total of only four factors extracted for the large miscellaneous sample: the language and problem-solving factors noted above, a factor that received substantial loadings only from the tactual functions perceptual tests, and a factor that received high loadings only from the Finger Tapping test. While the factor analyses probably differ from each other because of differences in the samples and the specifics of the variables included (which were not precisely the same), the two analyses taken together provide a reasonably good impression of the abilities tapped by the Halstead-Reitan. They can readily be described as verbal skills, complex problem-solving abilities, and various perceptual and motor skills. In some cases, a purely numerical ability factor may emerge as well as a factor representing the nonverbal memory abilities involved in the memory and location components of the Tactual Performance test. In general, when standard factor extraction termination procedures are used, in our case Kaiser's (1960) rule, the battery seems to be satisfactorily structured into four or five factors. It is interesting to note that the original Halstead (1947) analysis, even with its different tests and different factoring methods, also generated four factors.

Theoretical Foundations

There are really two theoretical bases for the Halstead-Reitan Battery, one contained in *Brain and Intelligence* and related writings of Halstead, the other in numerous papers and chapters written by Reitan and various collaborators (e.g., Reitan, 1966; Reitan & Wolfson, 1985). They are quite different from each other in many ways, and the difference may be partly accounted for by the fact that Halstead was not primarily a practicing clinician and was not particularly interested in developing his tests as psychometric instruments to be used in clinical assessment of patients. Indeed, he never published the tests. He was more interested in utilizing the tests to answer basic scientific questions in the area of brain-behavior relationships in general and frontal lobe function in particular. Reitan's program, on the other hand, can be conceptualized as an effort to demonstrate the usefulness and accuracy of Halstead's tests and related procedures in clinical assessment of brain-damaged patients. It is probably fair to say that Halstead's theory of biological intelligence and its factor analytically based four components (the central integrative field, abstraction, power, and the directional factor), as well as his empirical findings concerning human frontal lobe function, have not become major forces in modern clinical neuropsychology. However, they have had, in my view, a more subtle influence on the field.

Halstead was really the first to establish a human neuropsychology laboratory in which patients were administered objective tests, some of which were semiautomated, utilizing standard procedures and sets of instructions. His Chicago laboratory may have been the initial stimulus for the now common practice of trained technician administration of neuropsychological tests. Halstead was also the first to utilize sophisticated, multivariate statistics in the analysis of neuropsychological test data. Even though Reitan did not pursue that course to any great extent, other researchers with the Halstead-Reitan Battery have done so (e.g., Goldstein & Shelly, 1971, 1972). Thus, though the specifics of Halstead's theoretical work have not become well known and widely applied, the concept of a standard neuropsychological battery administered under laboratory conditions and consisting of objective, quantifiable procedures has made a major impact on the field of clinical neuropsychology. The other, perhaps more philosophical, contribution of Halstead was what might be described as his Darwinian approach to neuropsychology. He viewed his discriminating tests as measures of adaptive abilities, as skills that assured man's survival on the planet. Many neuropsychologists are now greatly concerned with the relevance of their test procedures to adaptation—the capacity to carry on functional activities of daily living and to live independently (Heaton & Pendleton, 1981). This general philosophy is somewhat different from the more traditional models emanating from behavioral neurology, in which there is a much greater emphasis on the more medical-pathological implications of behavioral test findings.

Reitan, while always sympathetic with Halstead's thinking, never developed a theoretical system in the form of a brain model or a general theory of the biological intelligence type. One could say that Reitan's great concern has always been with the empirical validity of test procedures. Such validity can be established only through the collection of large amounts of data obtained from patients with reasonably complete documentation of their medical/neurological conditions. Both presence and absence of brain damage had to be well documented, and if present, findings related to site and type of lesion had to be established. He has described his work informally as one large experiment, necessitating maximal consistency in the procedures used, and to some extent, the methods of analyzing the data. Reitan and his various collaborators represent the group that was primarily responsible for introduction of the standard battery approach to clinical neuropsychology. It is clear from reviewing the Reitan group's work that there is substantial emphasis on performing controlled studies with samples sufficiently large to allow for application of conventional statistical procedures. One also gets the impression of an ongoing program in which initial findings are qualified and refined through subsequent studies.

It would probably be fair to say that the major thrust of Reitan's research and writings has not been espousal of some particular theory of brain function, but rather an extended examination of the inferences that can be made from behavioral indices relative to the condition of the brain. There is a great emphasis on methods of drawing such inferences in the case of the individual patient. Thus, this group's work has always involved empirical research and clinical interpretation, with one feeding into the other. In this regard, there has been a formulation of inferential methods used in neuropsychology (Reitan & Wolfson, 1985) that provides a framework for clinical interpretation. Four methods are outlined: level of performance, pattern of performance, specific behavioral deficits (pathognomonic signs), and right-left comparisons. In other words, one examines for whether the patient's general level of adaptive function compares with that of normal individuals, whether there is some characteristic performance profile that suggests impairment even though the average score may be within normal limits, whether there are unequivocal individual signs of deficits, and whether there is a marked discrepancy in functioning between the two sides of the body.

In general, then, Reitan's theoretical framework is basically empirical, objective, and data oriented. An extensive research program, by now of about 35 years' duration, has provided the information needed to make increasingly sophisticated inferences from neuropsychological tests. It thereby constitutes to a significant extent the basis for clinical interpretation. The part of the system that remains subjective is the interpretation itself, but in that regard, Reitan (1964) has made the following remark: "Additional statistical methods may be appropriate for this problem but, in any case, progress is urgently needed to replace the subjective decision-making processes in individual interpretation that presently are necessary" (p. 46).

Standardization Research

The Halstead-Reitan Battery, as a whole, meets rigorous validity requirements. Following Halstead's (1947) initial validation the battery was cross-validated by Reitan (1955) and in several other laboratories (Russell et al., 1970; Vega & Parsons, 1967). As indicated above, reviews of validity studies with the Halstead-Reitan Battery have been written by Klove (1974) and Boll (1981). Validity, in this sense, means that all component tests of the battery that contribute to the impairment index discriminate at levels satisfactory for producing usable cutoff scores for distinguishing between brain-damaged and non-brain-damaged patients. The major exceptions, the Time Sense and Flicker Fusion tests, have been dropped from the battery by most of its users. In general, the validation criteria for these studies consisted of neurosurgical and other definitive neurological data. It may be mentioned, however, that most of these studies were accomplished before the advent of the CT scan, and it would probably now be possible to do more sophisticated validity studies, perhaps through correlating extent of impairment with quantitative measures of brain damage (e.g., CT scan density measures). In addition to what was done with Halstead's tests, validity studies were accomplished with tests added to the battery, such as the Wechsler scales, the Trail Making test and the Reitan Aphasia Screening tests, with generally satisfactory results (Reitan, 1966).

By virtue of the level of inferences made by clinicians from Halstead-Reitan Battery data, validity studies must obviously go beyond the question of presence or absence of brain damage. The first issue raised related to discriminative validity between patients with left-hemisphere and right-hemisphere brain damage. Such measures as Finger Tapping, the Tactual Performance test, the perceptual disorders sub-battery, and the Reitan Aphasia Screening test all were reported as having adequate discriminative validity in this regard. There have been very few studies, however, that go further and provide validity data related to more specific criteria such as localization and type of lesion. It would appear from one impressive study (Reitan, 1964) that valid inferences concerning prediction at this level must be made clinically, and one cannot call upon the standard univariate statistical procedures to make the necessary discriminations. This study provided the major impetus for Russell et al.'s (1970) neuropsychological key approach, which was in essence an attempt to objectify higher-order inferences.

There is one general area in which the discriminative validity of the Halstead-Reitan Battery is not particularly robust. The battery does not have great capacity to discriminate between brain-damaged patients and patients with functional psychiatric disorders, notably chronic schizophrenia. There is an extensive literature concerning this matter, but it should be said that some of the research contained in this literature has significant methodological flaws, leaving the findings ambiguous. It may also be pointed out that the constructors of the Halstead-Reitan did not have the intention of developing a procedure to discriminate between brain-damaged and schizophrenic patients, and the assumption that it should be able to do so is somewhat gratuitous. Furthermore, Heaton and Crowley (1981) find that with the exception of the diagnosis of chronic schizophrenia, the Halstead-Reitan Battery does a reasonably good job of differential diagnosis. They provided the following conclusion:

> The bulk of the evidence . . . suggests that for most psychiatric patient groups there is little or no relationship between the degree of emotional disturbance and level of performance on neuropsychological tests. However, significant correlations of this type are sometimes found with schizophrenic groups. (p. 492)

This matter remains controversial and has become exceedingly complex, particularly since the discovery of cerebral atrophy in a substantial portion of the schizophrenic population and the development of hypotheses concerning left-hemisphere dysfunction in schizophrenics (Flor-Henry & Yeudall, 1979). The point to be made here is that the user of the Halstead-Reitan Battery should exercise caution in interpretation when asked to employ the battery in resolving questions related to differential diagnosis between brain damage and schizophrenia. Some writers have advised the addition of some measure of psychiatric disability, such as the MMPI, when doing such assessments (Russell, 1975b, 1977).

Even though there have been several studies of the predictive validity of neuropsychological tests with children (Fletcher & Satz, 1980; Rourke, 1983) and other studies with adults that did not utilize the full Halstead-Reitan Battery (Meier, 1974), I know of no major formal assessment of the predictive validity of the Halstead-Reitan Battery accomplished with adults. Within neuropsychology, predictive validity has two aspects: predicting everyday academic, vocational, and social functioning and predicting course of illness. With regard to the former matter, Heaton and Pendleton (1981) document the lack of predictive validity studies using extensive batteries of the Halstead-Reitan type. However, they do report one study (Newman, Heaton, & Lehman, 1978) in which the Halstead-Reitan successfully predicted employment status on six-month followup. With regard to prediction of course of illness, there appears to be a good deal of clinical expertise in this regard, but no major formal studies in which the battery's capacity to predict whether the patient will get better, worse, or stay the same are evaluated. This matter is of particular significance in such conditions as head injury and stroke, because outcome tends to be quite variable in these conditions. The changes that occur during those stages are often the most significant ones related to prognosis (e.g., length of time unconscious).

In general, there has not been a great deal of emphasis on studies involving the reliability of the Halstead-Reitan Battery, probably because of the nature of the tests themselves, particularly with regard to the practice-effect problem, and because of the changing nature of those patients for whom the battery was developed. Those reliability studies that were done produced satisfactory results, particularly with regard to the reliability of the impairment index (Boll, 1981). The Category test can have its reliability assessed through the split-half method. In a study accomplished by Shaw (1966), a .98 reliability coefficient was obtained.

Norms for the Halstead-Reitan are available in numerous places (Russell et al., 1970; Vega & Parsons, 1967), but because the battery was never published as a single procedure, there is no published manual to which one can refer for definitive information. Schear (1984) has published a table of age norms for neuropsychiatric patients, but there are no published age- or education-corrected norms for the general population. However, several laboratories have collected local norms. A great deal is known about the influence of age and education on the various tests in the Halstead-Reitan Battery, but this information was never consolidated into tables of norms or through the formulation of equations for calculating appropriate corrections. Similarly, sex differences generally reported appear only on Finger Tapping, with women tapping slightly more slowly than men. It is somewhat unusual for a procedure in as widespread use as the Halstead-Reitan not to have a commercially published manual. However, detailed descriptions of the procedures as well as instructions for administration and scoring are available in several sources including Reitan and Wolfson (1985), Jarvis and Barth (1984), and Swiercinsky (1978).

In summary, the validity of the Halstead-Reitan seems well established by literally hundreds of studies, including several major cross-validations. These studies have implications for the concurrent, predictive, and construct validity of the battery. Reliability has not received nearly as much attention, but it seems apparent that the battery is sufficiently reliable not to compromise its validity. There are few age- or education-related norms, but the relevance of such norms to neuropsychological assessment, particularly with regard to age, is a controversial and unsettled matter. There is no commercially available manual for the battery, and so the usual kinds of information generally contained in a manual are not available in a single place to the test user. However, the relevant information is available in a number of separate sources.

Evaluation

The Halstead-Reitan Battery is without doubt the most widely used standard neuropsychological battery, at least in North America and perhaps throughout the world. Aside from its widespread clinical application, it is used in many multidisciplinary research programs as the procedure of choice for neuropsychological assessment. It therefore has taken on something of a definitive status and is viewed by many experts in the field as the state-of-the-art instrument for comprehensive neuropsychological assessment. Nevertheless, several criticisms of it have emerged over the years, and some of them are reviewed here. Each major criticism is itemized and discussed.

1. *The Halstead-Reitan Battery is too long and redundant.* The implication of this criticism is that pertinent, clinically relevant neuropsychological assessment can be accomplished in substantially less time than the 6 to 8 hours generally required to administer the full Halstead-Reitan battery. Other batteries are, in fact, substantially briefer than the Halstead-Reitan. Aside from simply giving fewer or briefer tests, another means suggested of shortening neuropsychological assessment is through a targeted, individualized approach rather than through routine administration of a complete battery. The difficulty with this latter alternative is that such an approach can generally be conducted only by an experienced clinician, and one sacrifices the clinician time and expense that can be saved through administration by trained technicians. The response to the criticism concerning length is generally that shortening of the battery correspondingly reduces its comprehensiveness, and one sacrifices examination of areas that may be of crucial significance in individual cases. Indeed, the battery approach was, in part, a reaction to the naiveté inherent in the use of single tests for "brain damage." The extent to which the clinician reverts to a single-test approach may reflect the extent to which there is a return to the simplistic thinking of the past. In general, the argument is that to cover adequately what must be covered in a standard, comprehensive assessment, the length of the procedure is a necessity. From the point of view of patient comfort and fatigue, the battery can be administered in several sessions over a period of days if necessary.

2. *The tests in the Halstead-Reitan Battery are insufficiently specific, both in regard to the functions they assess and the underlying cerebral correlates of those functions.* Most of the tests in the battery are quite complex, and it is often difficult to isolate the source of impairment within the context of a single test. Even as apparently simple a procedure as the Speech Perception test requires not only the ability to discriminate sounds, but to read, make the appropriate written response, and attend to the task. Therefore, failure on the test cannot unequivocally point to a specific difficulty with auditory discrimination. Difficulties of this type are even more pronounced in such highly complex procedures as the Category and Tactual Performance tests. This criticism eventuates in the conclusion that it is difficult to say anything meaningful about the patient's brain or about treatment because one cannot isolate the specific deficit. In Luria's (1973) terminology one cannot isolate the functional system that is involved, no less the link in that system that is impaired. Failure to do so makes it difficult if not impossible to identify the structures in the brain that are involved in the patient's impairment as well as to formulate a rehabilitation program, because one does not really know in sufficiently specific terms what the patient can and cannot do.

This criticism ideally requires a very detailed response, because it implies an approach to neuropsychological assessment substantially different from the one adopted by developers of the Halstead-Reitan. Perhaps the response can be summarized in a few points. The Halstead-Reitan Battery is founded on empirical rather than on content validity. Inferences are drawn on the basis of pertinent research findings and clinical observations rather than on the basis of what the tests appear to be measuring. The fact that one cannot partial out the various factors involved in successful or impaired performance on the Category test, for example, does not detract from the significant empirical findings related to this test based on studies of various clinical populations. In any event, Reitan, Hom, and Wolfson (1988) have shown that complex abilities, notably abstraction, are dependent upon the functioning of both cerebral hemispheres, and not on a localized unilateral system. The use of highly specific items in order to identify a specific system or system link is a procedure that is closely tied to the syndrome approach of behavioral neurology. Developers of the Halstead-Reitan typically do not employ a syndrome approach for several reasons. First, it depends almost exclusively on the pathognomonic signs method of inference to the neglect of other inferential methods, and second, the grouping together of specific deficits into a syndrome is felt to be more often in the brain of the examiner than of the patient. The lack of empirical validity of the so-called Gerstmann Syndrome is an example of this deficiency in this particular approach (Benton, 1961). Another major point is that the Halstead-Reitan Battery is a series of tests in which interpretation is based not on isolated consideration of each test taken one at a time, but on relationships among performances on all of the tests. Therefore, specific deficits can be isolated, in some cases at least, through intertest comparisons rather than through isolated examination of a single test. Returning to our example, the hypothesis that there is impairment on the Speech Perception test because of the patient's failure to read the items accurately can be evaluated through looking at the results of the aphasia screening or reading-achievement test given. Finally, complex tests are likely to have more ecological validity than simple tests of isolated abilities. Thus, the Category test or Tactual Performance test results can tell the clinician more about real-world functioning than can the simpler tests. Simple tests were developed in the context of neurological diagnosis, while the tests in the Halstead-Reitan Battery seem more oriented to assessing adaptive functioning in the environment.

3. *The Halstead-Reitan Battery is not sufficiently comprehensive, particularly in that it completely neglects the area of memory.* The absence of formal memory testing in this battery has been noted by many observers and appears to be a valid criticism. On the face of it, it would appear that the battery would be incapable of identifying and providing meaningful assessments of patients with pure amnesic syndromes (e.g., patients with Korsakoff's syndrome). The absence of formal memory testing as part of the Halstead-Reitan is something of a puzzlement; although memory is involved in many of the tests, it is difficult to isolate the memory component as a source of impairment. Such isolation is readily achieved through such standard, commonly available procedures as list or paired associate learning.

We know of no formal response to this criticism, but the point of view could be taken that pure amnesic syndromes are relatively rare, and the Halstead-Reitan Battery would probably not be the assessment method of choice for many of the rarely occurring specific syndromes. I would view this response as weak in view of the reported significance of memory defect in a number of disorders (Butters, 1983). Apparently, Halstead did not work with patients of those types, particularly patients with Alzheimer's and Huntington's disease, and so may have failed to note the significance of memory function in those disorders. However, this criticism is probably the one most easily resolved, because all that is required is addition of some formal memory testing to the battery. Many clinicians have already added all or parts of the Wechsler Memory Scale or similar procedures.

4. *The Halstead-Reitan Battery cannot discriminate between brain-damaged and schizophrenic patients.* This matter has already been discussed, and most of the evidence (Heaton & Crowley, 1981) indicates that the performance of chronic schizophrenics on the Halstead-Reitan may be indistinguishable from that of the patient with generalized, structural brain damage. There are essentially two classes of response to this criticism. First, there is a disclaimer that the Halstead-Reitan was ever designed for this kind of differential diagnosis, and so it is not surprising that it fails when it is inappropriately used for that purpose. Second, and perhaps much more significant, is the finding that many schizophrenics have brain atrophy, as assessed by CT scan, and tests of the Halstead-Reitan type can now be viewed as accurately identifying the behavioral correlates of that condition (Weinberger & Wyatt, 1982). Furthermore, there are now several studies indicating that schizophrenia is a neuropsychologically heterogeneous condition, and that there is a lack of relationship betwen neuropsychological test results and psychiatric diagnosis in the case of several psychiatric disorders (Goldstein & Shelly, 1987; Townes et al., 1985.)

5. *Findings reported from Reitan's laboratory cannot be replicated in other settings.* Here we have particular reference to the criticisms raised by Smith of Reitan's early Wechsler-Bellevue laterality studies. In a series of papers, Smith (1965, 1966a, 1966b) presented empirical and theoretical arguments against the reported finding that patients with left-hemisphere lesions had lower verbal than performance IQs on the Wechsler-Bellevue, while the reverse was true for patients with right-hemisphere brain damage. Smith was unable to replicate these findings in patients with lateralized brain damage for whom he had Wechsler-Bellevue data; he also presented theoretical arguments against the diagnostic and conceptual significance of this finding. Klove (1974) analyzed the Smith versus Reitan findings in terms of possible age and neurological differences between the studies. Reviewing the research done to the time of writing, he also concluded that most of the research, with Smith as the only pronounced exception, essentially confirmed Reitan's original findings.

In summary, many criticisms have been raised o the Halstead-Reitan as a comprehensive, standar neuropsychological assessment system. While pertinent and reasonable responses have been made to mos or all of these critiques, members of the professio have nevertheless sensed in recent years the desire t develop alternative procedures. Despite the pertinen replies to criticisms, there appear to be many clinicians who still feel that the Halstead-Reitan Battery i too long, *does* neglect memory, and in many cases i insufficiently specific. Some holders of these view adopted an individualized approach, or modified th Halstead-Reitan, while others sought alternative standard batteries.

The Luria-Nebraska Neuropsychological Battery

History

This procedure, previously known as the Luria South Dakota Neuropsychological Battery or as Standard Version of Luria's Neuropsychologic

Tests, was first reported on in 1978 (Golden, Hammeke, & Purisch, 1978; Purisch, Golden, & Hammeke, 1978) in the form of two initial validity studies. One could provide a lengthy history of this procedure, going back to Luria's original writings, or a brief one recording only events that occurred since the time of preparation of the two publications cited above. We will take the latter alternative, for reasons that will become apparent. Prior to the past quarter of a century, Luria was a shadowy figure to most English-speaking neuropsychologists. It was known that he was an excellent clinician who had developed his own methods for evaluating patients as well as his own theory, but the specific contents were unknown until translations of some of his major works appeared in the 1960s (e.g., Luria, 1966). However, when these works were read by English-speaking professionals, it became apparent that Luria did not have a standard battery of the Halstead-Reitan type and did not even appear to use standardized tests. Thus, while his formulations and case presentations were stimulating and innovative, nobody knew quite what to do with these materials in terms of practical clinical application. One alternative, of course, was to go to the Soviet Union and study with Luria. In fact, Anne-Lise Christensen did just that and reported what she had learned in a book called *Luria's Neuropsychological Investigation* (Christensen, 1975a). The book was accompanied by a manual and a kit containing test materials used by Luria and his co-workers (Christensen, 1975b, 1975c). Even though some of Luria's procedures previously appeared in English in the *Higher Cortical Functions* (1966) and *Traumatic Aphasia* (1970), they were never presented in a manner that encouraged direct administration of the test items to patients. With Christensen's publications, the English-speaking public had in hand a manual and related materials that could be used to administer some of Luria's tests. These materials did not contain information relevant to standardization of these items. There was no scoring system, norms, data regarding reliability and validity, or review of research accomplished with the procedure as a standard battery. This work was taken on by a group of investigators under the leadership of Charles J. Golden and was initially reported on in the two 1978 papers cited above. Thus, in historical sequence, Luria adopted or developed these items over the course of many years, Christensen published them in English but without standardization data, and finally Golden and collaborators provided quantification and standardization. Since that time, Golden's group as well as other investigators have produced a massive amount of studies with what is now known as the Luria-Nebraska Neuropsychological Battery. The battery was published in 1980 by Western Psychological Services (Golden, Hammeke, & Purisch, 1980) and is now extensively used in clinical and research publications. An alternate form of the battery is now available (Golden, Purisch, & Hammeke, 1985), as is a children's version (Golden, 1981a).

Structure and Content

The Luria-Nebraska is an evolving procedure, and the details presented here will no doubt change over the years. However, the basic structure of the battery will probably remain essentially the same. The current version contains 269 items, each of which may be scored on a 2- or 3-point scale. A score of 0 indicates normal performance. Some items may receive a score of 1, indicating borderline performance. A score of 2 indicates clearly abnormal performance. The items are organized into the categories provided in the Christensen kit (Christensen, 1975c), but while Christensen organized the items primarily to suggest how they were used by Luria, in the Luria-Nebraska version the organization is presented as a set of quantitative scales. The raw score for each scale is the sum of the 0, 1, and 2 item scores. Thus, the higher the score, the poorer the performance. Because the scales contain varying numbers of items, raw scale scores are converted to T scores with a mean of 50 and a standard deviation of 10. These T scores are displayed as a profile on a form prepared for that purpose. The scores for the individual items may be based on speed, accuracy, or quality of response. In some cases, two scores may be assigned to the same task, one for speed and the other for accuracy. These two scores are counted as individual items. For example, one of the items is a block counting task, with separate scores assigned for number of errors and time to completion of the task. In the case of time scores, blocks of seconds are associated with the 0, 1, and 2 scores. When quality of response is scored, the manual provides both rules for scoring, and, in the case of copying tasks, illustrations of figures representing 0, 1, and 2 scores.

The 269 items are divided into 11 content scales, each of which is individually administrable. In Table 10.2 we present the name of each content scale, a brief description of each scale, and a sample item. In the alternate form of the battery, the names of the content scales have been replaced by abbreviations. Thus, the scales listed in Table 10.2 are referred to as the C1 through C11 scales.

Table 10.2. The Luria-Nebraska Major Scales

SCALE	DESCRIPTION AND SAMPLE ITEM
Motor	Contains items assessing a wide variety of motor skills ranging from simple movements to more complex tasks including pretended movements and movements associated with complex verbal instructions. Sample Item: If I knock hard, you knock gently; if I knock gently, then knock hard.
Rhythm	Contains measures of primarily nonverbal auditory perception such as pitch discrimination and appreciation of rhythmic patterns. Sample Item: Now you are going to hear two tones on a tape from this tape recorder. I want you to tell me whether the tones you hear are the same or different.
Tactile	This scale is basically a sensory examination and contains measures of light touch localization, two point discrimination, and tactile recognition. Sample Item: I am going to touch you with the eraser end of the pencil. Tell me where I am touching you (touching fingers, palm and forearm of each upper extremity).
Vision	Contains items assessing basic visual perceptual skills as well as more complex visual-spatial tasks. Sample Item: I am now going to show you several pictures. Tell me what they are. (Subject is presented with cards containing photographs of common objects.)
Receptive Speech	Contains items ranging from perception of single sounds to comprehension of complex grammatical structures. Sample Item: Someone has just told you that "Arnie hit Tom." Who was the victim?
Expressive Speech	Contains items assessing ability to repeat sounds, words, and word groups, to name objects, and to produce narrative speech. Sample Item: Please make up a speech for me about the conflict between generations.
Writing	Contains items assessing ability to analyze words into letters and to write under varying conditions. Sample Item: Please write: physiology; probabilistic
Reading	Contains items assessing ability to make letter to sound transformations and to read simple material. Sample Item: I am going to show you several cards. Read the word on each card.
Arithmetic	Contains items assessing knowledge of numbers, number concept, and ability to perform simple calculations. Sample Item: Please solve these problems. You may also write them down if you like: (1) 3 + 4; (2) 6 + 7
Memory	A brief, formal memory examination including list learning, immediate memory, short-term memory with interference, and paired-associate learning. Sample Item: Now I am going to read you a short story. I want you to listen carefully because when I am finished I want you to repeat to me all that you can remember about the story.
Intellectual Processes	A brief intellectual assessment containing sequencing, problem solving, and abstraction items. Sample Item: What is meant by these expressions: (1) "iron hand"? (2) "green thumb"?

In addition to these 11 content scales, there are three derived scales that appear on the standard profile form: the Pathognomonic, Left Hemisphere, and Right Hemisphere scales. The Pathognomonic scale contains items from throughout the battery found to be particularly sensitive to presence or absence of brain damage. The Left and Right Hemisphere scales are derived from the Motor and Tactile scale items that involve comparisons between the left and right side of the body. They therefore reflect sensory-motor asymmetries between the two sides of the body.

Several other scales have been developed by Golden and various collaborators, all of which are based on different ways of scoring the same 269 items. These special scales include new (empirically derived) right- and left-hemisphere scales (McKay & Golden, 1979a), a series of localization scales (McKay & Golden, 1979b), a series of factor scales (McKay & Golden, 1981), and double discrimination scales (Golden, 1979). The new right-and left-hemisphere scales contain items from throughout the battery and are based upon actual comparisons among patients with right, left hemisphere, and diffuse brain damage. The localization scales are also empirically derived (McKay & Golden, 1979b), being based on studies of patients with localized brain lesions. There are frontal, sensory-motor, temporal, and parieto-occipital scales for each hemisphere. The factor scales are based on extensive factor analytic studies of the battery involving factor analyses of each of the major content scales (e.g., Golden & Berg, 1983). The factor scales and associated codes are listed below (see Table 10.3). The code consists of an abbreviation for the major content scale followed by the number of the scale (e.g., M3 is the third factor scale derived from the Motor scale).

Table 10.3. The Luria-Nebraska Factor Scales

CODE	FACTOR SCALES
M1	Kinesthetic-Based Movement
M2	Drawing Speed
M3	Fine Motor Speed
M4	Spatial-Based Movement
M5	Oral Motor Skills
Rh1	Rhythm and Pitch Perception
T1	Simple Tactile Sensation
T2	Stereognosis
V1	Visual Acuity and Naming
V2	Visual-Spatial Organization
Rc1	Phonemic Discrimination
Rc2	Relational Concepts
Rc3	Concept Recognition
Rc4	Verbal-Spatial Relationships
Rc5	Word Comprehension
Rc6	Logical Grammatical Relationships
E1	Simple Phonetic Reading
E2	Word Repetition
E3	Reading Polysyllabic Words
Rg1	Reading Complex Material
Rg2	Reading Simple Material
W1	Spelling
W2	Motor Writing Skill
A1	Arithmetic Calculations
A2	Number Reading
Me1	Verbal Memory
Me2	Visual and Complex Memory
I1	General Verbal Intelligence
I2	Complex Verbal Arithmetic
I3	Simple Verbal Arithmetic

The new right- and left-hemisphere, localization, and factor scales may all be expressed in T scores with a mean of 50. The double discrimination scales are still in an experimental phase, but have been shown to be effective in diagnosis of multiple sclerosis (Golden, 1979). This method involves development of two scales: one contains items on which patients with a particular diagnosis do worse than the general neurological population; the other contains items on which patients do better. Classification to the specific group is made when scores are in the appropriate range on both scales. There are also two scales that provide global indices of dysfunction and are meant as equivalents to the Halstead Impairment Index. They are called the Profile Elevation and Impairment scales.

The Luria-Nebraska procedure involves an age and education correction. It is accomplished through computation of a cutoff score for abnormal performance based on an equation that takes into consideration both age and education. The computed score is called the critical level and is equal to .214 (Age) + 1.47 (Education) + 68.8 (Constant). Typically, a horizontal line is drawn across the profile at the computed critical level point. The test user has the option of considering scores above the critical level, which may be higher or lower than 60, as abnormal.

As indicated above, extensive factor analytic studies have been accomplished, and the factor structure of each of the major scales has been identified. These analyses were based on item intercorrelations, rather than on correlations among the scales. It is important to note that most items on any particular scale correlate more highly with other items on that scale than they do with items on other scales (Golden, 1981b). This finding lends credence to the view that the scales are at least somewhat homogeneous, and thus that the organization of the 269 items into those scales can be justified.

Theoretical Foundations

As in the case of the Halstead-Reitan Battery, one could present two theoretical bases for the Luria-Nebraska, one revolving around the name of Luria and the other around the Nebraska group—Golden and his collaborators. This view is elaborated on in Goldstein (1986). It is to be noted in this regard that Luria himself had nothing to do with the development of the Luria-Nebraska Battery, nor did any of his coworkers. The use of his name in the title of the battery is, in fact, somewhat controversial, and seems to have been essentially honorific in intent, recognizing his development of the items and the underlying theory for their appliction. Indeed, Luria died some time before publication of the battery but was involved in the preparation of the Christensen materials, which he endorsed. Furthermore, the method of testing employed by the Luria-Nebraska was not Luria's method, and the research done to establish the validity, reliability, and clinical relevance of the Luria-Nebraska was not the kind of research done by Luria and his collaborators. Therefore, our discussion of the theory underlying the Luria-Nebraska Battery will be based on the assumption that the only connecting link between Luria and that procedure is the set of Christensen items. Thus, it becomes clear that the basic theory underlying the development of the Luria-Nebraska is based on a philosophy of science that stresses empirical validity, quantification, and application of established psychometric procedures. Indeed, as pointed out elsewhere (Goldstein, 1982, 1986), it is essentially the same epistemology that characterizes the work of the Reitan group.

The general course charted for establishment of quantitative, standard neuropsychological assessment batteries involves several steps: (a) determining whether the battery discriminates between brain-damaged patients in general and normal controls; (b) determining whether it discriminates between patients with structural brain damage and conditions that may be confused with structural brain damage, notably various functional psychiatric disorders; (c) determination of whether the procedure has the capacity to lateralize and regionally localize brain damage; (d) determination of whether there are performance patterns specific to particular neurological disorders, such as alcoholic dementia or multiple sclerosis. In proceeding along this course, it is highly desirable to accomplish appropriate cross-validations and to determine reliability. This course was taken by Golden and his collaborators, in some cases with remarkable success. Because the relevant research was accomplished during recent years, it had the advantages of being able to benefit from the new brain imaging technology, notably the CT scan, and the application of high-speed computer technologies, allowing for extensive use of powerful multivariate statistical methods. With regard to methods of clinical inference, the same methods suggested by Rietan—level of performance, pattern of performance, pathognomonic signs, and right-left comparisons—are the methods generally used with the Luria-Nebraska.

Adhering to our assumption that the Luria-Nebraska bears little resemblance to Luria's methods and theories, there seems little point in examining the theoretical basis for the substance of the Luria-Nebraska Battery. For example, it seems that there would be little point in examining the theory of language that underlies the Receptive Speech and Expressive Speech scales or the theory of memory that provides the basis for the Memory scale. An attempt to produce such an analysis was made by Spiers (1981), whc examined the content of the Luria-Nebraska scale and evaluated it with reference not so much to Luria' theories but to current concepts in clinical neuropsychology in general. However, despite the thoroughness of the Spiers review, it seems to miss the essentia point that the Luria-Nebraska is a procedure base primarily on studies of empirical validity. One ca fault it on the quality of its empirical validity studies but not on the basis that it utilizes such an approach. I therefore appears that the Luria-Nebraska Batter does not constitute a means of using Luria's theor and methods in English-speaking countries, but rathe is a standardized psychometric instrument with established validity for certain purposes and reliability. Th choice of using items selected by Christensen (1975 to illustrate Luria's testing methods was, in retrospec probably less crucial than the research methods chosen to investigate the capabilites of this item se Indeed, it is somewhat misleading to characteri these items as "Luria's tests," because many of the are standard items used by neuropsychologists ar neurologists throughout the world. Surely, one cann describe asking a patient to interpret proverbs determine two-point thresholds as being exclusive "Luria's tests." They are, in fact, venerable, wide used procedures.

Standardization Research

Fortunately, there are published manuals for t Luria-Nebraska (Golden, Hammeke, & Purisc

1980; Golden, Purisch, & Hammeke, 1985) that describe the battery in detail and provide pertinent information relative to validity, reliability, and norms. There are also several review articles (e.g., Golden, 1981b; Purisch & Sbordone, 1986) that comprehensively describe the research done with the battery. A brief review of this material shows that satisfactory discriminative validity has been reported in studies directed toward differentiating miscellaneous brain-damaged patients from normal controls and from chronic schizophrenics. Cross-validations were generally successful, but Shelly and Goldstein (1983) could not fully replicate the studies involved with discrimination between brain-damaged and schizophrenic patients. Discriminative validity studies involving lateralization and localization achieved satisfactory results, but the localization studies were based on small samples. Quantitative indices from the Luria-Nebraska were found to correlate significantly with CT scan quantitative indices in alcoholic (Golden, Graber, Blose, Berg, Coffman, & Block, 1981) and schizophrenic (Golden, Moses et al., 1980) samples. There have been several studies of specific neurological disorders, including multiple sclerosis (Golden, 1979), alcoholism (Chmielewski & Golden, 1980), Huntington's disease (Moses, Golden, Berger, & Wisniewski, 1981), and learning-disabled adults (McCue, Shelly, Goldstein, & Katz-Garris, 1984), all with satisfactory results in terms of discrimination.

The test manual reports reliability data. Test-retest reliabilites for the 13 major scales range from .78 to .96. The problem of inter-judge reliability is generally not a major one for neuropsychological assessment because most of the tests used are quite objective and have quantitative scoring systems. However, there could be a problem with the Luria-Nebraska, because the assignment of 0, 1, and 2 scores sometimes requires a judgment by the examiner. During the preliminary screening stage in the development of the battery, items in the original pool that did not attain satisfactory inter-judge reliability were dropped. A 95% interrater agreement level was reported by the test constructors for the 282 items used in an early version of the battery developed after the dropping of those items. The manual contains means and standard deviations for each item based on samples of control, neurologically impaired, and schizophrenic subjects. An alternate form of the battery is available. To the best of our knowledge, there have been no predictive validity studies. It is unclear whether there have been studies addressed to the issue of construct validity. Stambrook (1983) suggested that studies involved with item-scale consistency, factor analysis, and correlation with other instruments are construct validity studies, but it does not appear to us that they are directed toward validation of Luria's constructs. The attempt to apply Luria's constructs has not in fact involved the empirical testing of specific hypotheses derived from Luria's theory. Thus, we appear to have diagnostic or discriminative validity established by a large number of studies. There also seems to be content validity, because the items correlate most highly with the scale to which they are assigned, but the degree of construct validity remains unclear. For example, there have been no studies of Luria's important construct of the functional system or of his hypotheses concerning the role of frontal lobe function in the programming, regulation, and verification of activity (Luria, 1973).

Evaluation

It is well known that the Luria-Nebraska Battery, at this writing, remains a controversial procedure, and several highly critical reviews of it have appeared in the literature. Adams (1980) criticized it primarily on methodological grounds, Spiers (1981) on the basis that it was greatly lacking in its capacity to provide a comprehensive neurophychological assessment, Crosson and Warren (1982) because of its deficiencies with regard to assessment of aphasia and aphasic patients, and Stambrook (1983) on the basis of a number of methodological and theoretical considerations. Replies were written to several of these reviews (e.g., Golden, 1980), and a rather heated literature controversy eventuated. This literature was supplemented by several case studies (e.g., Delis & Kaplan, 1982), in which it was shown that the inferences that would be drawn from the Luria-Nebraska were incorrect with reference to documentation obtained for those cases.

These criticisms can be divided into general and specific ones. Basically, there are two general criticisms: (a) the Luria-Nebraska Battery does not reflect Luria's thinking in any sense, and his name should not be used in describing it; and (b) there are several relatively flagrant methodological difficulties involved in the standardization of the procedure. The major specific criticisms primarily involve the language-related and memory scales. With regard to aphasia, there are essentially two points. First, there is no system provided, nor do the items provide sufficient data to classify the aphasias in terms of some contemporary system (e.g., Goodglass & Kaplan, 1983). Second, the battery is so language-oriented that patients with aphasia may fail many of the non-language tasks because of failure to comprehend the test instructions or to make the appropriate verbal responses indicative of a correct answer. For example, on the Tactile scale, the patient must name objects placed in the hands. Patients with anomia or anomic aphasia will be unable to do that even though their tactile recognition skills may be perfectly normal. With regard to memory, the Memory scale is criticized because of its failure to provide a state-of-the-art comprehensive memory assessment (Russell, 1981). Golden has responded to this criticism through adding additional items involving delayed recall to the alternate form of the battery.

In providing an evaluation of the Luria-Nebraska, one can only voice an opinion, as others have, since its existence has stimulated a polarization into "those for it" and "those against it." I would concur with Stambrook's (1983) view, which essentially is that it is premature to make an evaluation, and that major research programs must be accomplished before an informed opinion can be reached. This research involves more definitive validation with a greatly expanded data base, an evaluation of the actual constructs on which the procedure is based, and assessment of its clinical usefulness relative to other established procedures such as the Halstead-Reitan or individual approaches. The following remark by Stambrook (1983) appears to reflect a highly reasoned approach to this issue: "The clinical utility of the LNNB does not depend upon either the publisher's and test developer's claims, or on conceptual and methodological critiques, but upon carefully planned and well-executed research" (p. 266). In this regard, one might note the discrepancy between the nearly half-century of work with Halstead's test and the barely ten years at this writing of work with Luria-Nebraska. Various opinions have also been raised with regard to whether it is proper to utilize the Luria-Nebraska in clinical situations. My view of the matter would be that it may be so used as long as inferences made from it do not go beyond what can be based on the available research literature. In particular, the test consumer should not be led to believe that administration and interpretation of the Luria-Nebraska Battery provide an assessment of the type that would have been conducted by Luria and his coworkers, or that one is providing an application of Luria's method. The procedure is specifically not Luria's method at all, and the view that it provides valid measures of Luria's constructs and theories has not been verified. Even going beyond that point, attempts to verify some of Luria's hypotheses (e.g., Drewe, 1975; Goldberg & Tucker, 1979) have not always been completely successful. Therefore, clinical interpretations, even when they are based on Luria's actual method of investigation, may be inaccurate because of inaccuracies in the underlying theory.

SUMMARY AND CONCLUSIONS

In the first part of this chapter, general problems in the area of standardization of comprehensive neuropsychological test batteries were discussed, while the second part contained brief reviews of the two most widely used procedures, the Halstead-Reitan and the Luria-Nebraska. It was generally concluded that these batteries have their advantages and disadvantages. The Halstead-Reitan is well established and detailed but also lengthy and cumbersome, and neglects certain areas, notably memory. The Luria-Nebraska is also fairly comprehensive and briefer than the Halstead-Reitan but is currently quite controversial and is thought to have major deficiencies in standardization and rationale, at least by some observers. I have taken the view that all of these standard batteries are screening instruments, but not in the sense of screening for presence or absence of brain damage. Rather, they may be productively used to screen a number of functional areas, such as a memory, language, or visual-spatial skills, that may be affected by brain damage. With the development of the new imaging techniques in particular, it is important that the neuropsychologist not simply tell the referring agent what he or she already knows. Th unique contribution of standard neuropsychologica assessment is the ability to describe functioning i many crucial areas on a quantitative basis. The exten to which one procedure can perform this type of tas more accurately and efficiently than other procedure will no doubt greatly influence the relative acceptabil ity of these batteries by the professional community

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Chapter VI

VOCATIONAL ASSESSMENT: FORMAL AND INFORMAL EVALUATION AND PRELIMINARY PLANNING

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INTRODUCTION

As part of the societal and cultural values to which we have all been exposed, work, as a value, has had far reaching consequences for all of us in that society. Freud posited that the meaning of life is to love and to work. Erikson wrote that it is primarily the inability to settle on an occupational identity which disturbs young people. For those of us in the field of rehabilitation, a primary objective of the rehabilitation process is the optimal vocational adjustment of disabled clients.

A necessary step in the achievement of this objective is a thorough, accurate and complete vocational assessment of a particular client's actual and potential level of functioning as this often serves as the foundation for further rehabilitation planning and programming. This assessment needs to include an evaluation of the individual's current level of vocational skills, abilities, strengths and deficits as well as a measure of his or her vocational interests, aptitudes, abilities, basic academic skill levels, work values and working condition preferences. Less tangible, but of equal importance, is the assessment of the client's realism regarding a vocational choice. Factors such as his or her own self-appraisal, knowledge of occupational and educational options, career maturity, and overall attitude toward work, education or training need to be considered. In the words of Lytel (1978):

> The counselor working with an emotionally disabled client is confronted with psychological limitations that may affect the client's work behavior in a variety of ways that are difficult to anticipate. With individuals who have a significant mental health treatment record, counselors may be reluctant to enter in rehabilitation plans because of a lack of convincing indicators of employability. As a result of this lack of information, a premature, unfounded decision may be made that a mental health referral is unemployable. To be effective in assessing the emotionally disabled client's employability, the

> counselor should not rely on a single indicator, but must use several types of information. In listing the optimal characteristics of employability in mental health cases, Simmons (1965) included high compatibility among occupational choice, desired rewards on the job, personal values, and occupational qualifications. Combining information regarding the client's tested aptitudes with the counselor's appraisal of relevant client self-perceptions can offer a helpful synthesis in determining the employability characteristics of the emotionally disabled referral (p. 134).

Vocational assessment, then, serves a multitude of functions. It is the purpose of this chapter to examine these functions in detail. In addition, these authors will review the environmental factors which have an impact upon the assessment process, procedural and interpersonal; the administration and interpretation of vocational assessment batteries; vocational exploration and planning; the differences inherent in testing special population groups; and finally case material which is illustrative of success and failure and which has its roots in the vocational assessment process.

A Rationale for the Justification of Vocational Assessment.

The purpose of assessment, the first or diagnostic phase in the psychiatric rehabilitation process, has been summarized by Hursh (1984):

- To screen individuals for decision-making purposes.
- To determine eligibility for services. According to most agency and service systems, such as the state-federal rehabilitation system, eligibility must be determined prior to identification of needed services.
- To identify training needs, including the identification of:
  a) functional strengths and deficits;
  b) characteristics of environmental settings which will support or act as barriers to independent functioning;
  c) services needed to increase individual strengths and environmental supports and reduce or eliminate individual deficits or environmental barriers;
  d) optimal functional outcome as a result of rehabilitation service delivery.
- To monitor individual progress through and throughout service delivery.
- To evaluate process and outcome variables relative to rehabilitation success (pp. 4-5).

"The objectives of assessment...reflect the range and complexity of decision making incidents that occur throughout the rehabilitation process." In order to respond to such questions, the rehabilitation practitioner must have available assessment strategies which "attend to different information needs at specific times" (p. 5).

Nevertheless, the rehabilitation practitioner who works with the individual with a psychiatric disability must rely on various means of externally imposed data gathering procedures from which to draw hypotheses, in a logical albeit predictive manner, and thereby formulate a plan of action. In other words, despite the lack of empirical research findings to support the validity of one particular kind or method of data gathering or assessment procedure to effectuate this goal, the practitioner must not only be sufficiently knowledgeable to draw upon what is best - most useful, most relevant, most workable, most efficient - from currently existing assessment procedures, but also to understand and interpret such data so that it yields operational guidelines, concrete recommendations and specific modes of adaptability.

Vocational evaluation is a diagnostic procedure in the overall assessment process whether it takes the form of interviewing techniques, psychometric techniques, work sample or situational assessment techniques or job site techniques. And, while recognizing that the track record of vocational evaluation with the psychiatrically disabled may be without statistically significant results (Cohen & Anthony, 1984; Hursh, 1984; Neff, 1970), it is, nonetheless, the state of the art as it presently exists.

One factor most often overlooked by numerous critics in the area of psychiatric vocational rehabilitation is that of the practitioner's working and usable knowledge regarding the process of vocational evaluation and what information such evaluations yield. Moreover, one cannot operationalize test results compiled from vocational evaluation procedures unless there is a basic understanding of what those results mean, how to communicate them and how to integrate them. Traditionally, the vocational rehabilitation counselor secures vendors to provide him or her with a vocational assessment of a particular client. Once the evaluation is completed the vocational counselor receives a report which he or she then ideally utilizes to make vocational training or job placement plans with the client. The report contains neat phrases concerning manual dexterity, visual-spatial relationships, vocational interests, work readiness habits and various other work related skills. With the non-psychiatrically disabled client the process then proceeds smoothly towards a successful rehabilitation outcome. With the psychiatrically disabled client this is most often not the case.

Psychiatric illness does not strike a single limb or vertebrae or nerve ending. Psychiatric illness is a pervasive phenomenon particularly with those individuals who suffer with a chronic mental illness. If we accept the definition formulated by Detre and Zarecki (1971),

> A person is considered to have a psychiatric illness..."when we see evidence of social dysfunctioning coupled with symptoms of psychological and

> biologic discomfort, and believe that the dysfunctioning and discomfort are caused by disturbances in the mechanisms that regulate mood and cognition" (p. 23).

then diagnostic or evaluative procedures must be examined and understood by all involved. Social dysfunctioning, behavioral symptomatology, and disturbances in the mechanisms of the body which regulate thinking and emotional stability or lability are far more complex handicaps to deal with in the vocational evaluation process than is any single physical or mental disability. Data compiled on an individual must first be understood in light of the person's disabling condition before it can be interpreted and thereafter utilized in a rational rehabilitation planning process.

Similarly, the mental health worker confronted with test results emanating from a vocational evaluation must understand the content of such an evaluation if he or she is to facilitate and support the client through the transition into the world of work. Sound treatment is based on a thorough and accurate assessment. If the assessment contains evaluative data which the clinician does not understand, and just as importantly cannot utilize, then the entire process is a futile exercise among professionals who operate within their particular domain of expertise and presume that once they have "done their thing" the job is done and their responsibility ends.

It is important at this point to illustrate this state of affairs as it currently has real impact on the vocational rehabilitation of persons with chronic mental illness. The mental health clinician receives a report from the local vocational evaluation and workshop facility which addresses the results of a client's performance on work samples in various simulated work settings. The report includes statements of the individual's manual dexterity in parts assembly, his or her productivity rate on an assembly line task, some observations regarding responsiveness to following directions and his or her high degree of distractibility and attention seeking behavior. The report concludes with a statement addressing the need for the client to continue in the work evaluation setting. After another period of extended work evaluation and personal work adjustment training the vocational evaluator sends his or her final report which states that the client is not suitable for vocational training or competitive employment at this time, and that the sheltered workshop job-slots are completely filled. The case is turned over to the state vocational rehabilitation counselor for disposition with a courtesy correspondence to the mental health clinician. It is possible that: (1) if the mental health clinician knew something about the vocational evaluation process in the initial stages, the client would not have been referred for the evaluation at that point; (2) if the mental health clinician understood the results from psychometric testing conducted previously, attempts could have been made to individualize the vocational work evaluation in the first place, or (3) if the mental health clinician had a working knowledge of the process of vocational evaluation, plans could have been formalized to place the client in such a program at less frequent intervals and thereby use the alternate daytime for partial hospital programming and/or ongoing therapeutic intervention specifically geared toward adjustment in the work setting.

On the other hand, the vocational evaluator receives the psychiatric evaluation from the local mental health facility which delineates diagnosis, medication levels, past psychiatric history and/or hospitalization, frequency of treatment sessions and ongoing intra-or interpersonal problem areas with a statement that the client would like to return to work. At times in complete disregard of the nature of psychiatric, psychological and social problems, the client is placed in a ready-made work site setting where a standardized package of work sample tasks is utilized. The client is "plugged in" and the evaluation proceeds. Previous psychometric testing is reviewed. However, since the vocational evaluator has more faith in his or her chosen work samples than in aptitude or interest testing, which appear to him or her to be too abstract and not of real utility in the work place in light of job market demands and ease of placement, the evaluation follows the prescribed regimen, sometimes in direct contrast to the earlier testing results. The client with right-hemisphere deficits who lacks visuo-spatial skills is placed on an assembly line task which requires the manipulation and reassembly of small motor parts. Very shortly thereafter he or she is described as highly distractible and attention-seeking.

Thus, the assessment phase, most critical to all future rehabilitation efforts, has been a dismal failure. Each professional has functioned within his or her own operational framework, has no understanding of what the other's data collection methodology could possibly mean, and therefore will not find it relevant much less usable.

The pervasiveness of this problem has been documented in a recent survey conducted by the Center for Rehabilitation Research and Training in Mental Health at Boston University (Hursh, 1984) regarding vocational evaluation services for psychiatrically disabled persons. A survey questionnaire was developed and distributed on a national level to vocational evaluators, administrators and service providers:

(1) to identify tests and procedures currently being used with psychiatrically disabled persons;

(2) to identify characteristics (predictors) which evaluators believe relate to future vocational performances;

(3) to identify how satisfied practitioners are with current evaluations "technology" in working with psychiatrically disabled individuals;

(4) to identify areas of need in vocational evaluation practice with psychiatrically disabled persons (p. 1).

The study concluded with the following statement:

> ...Although psychometric tests continue to be widely used, they do not provide information about work adjustment or interpersonal skills or relate to future vocational outcome...while work samples have been primary tools of vocational evaluations, they are not viewed as a significant tool with psychiatrically disabled persons...Situational assessment is widely used...and viewed as related to vocational outcome...Unfortunately the scope of situational practice is limited and situational activity is not clearly defined...Job site evaluation is seen as a viable and effective tool but is not widely used...
>
> Clearly, practitioners see that for psychiatrically disabled individuals, traditional tests used in traditional ways do not provide information useful for rehabilitation programming efforts...Training for members of the overall evaluation team to understand how to integrate vocational information and to better understand vocational functioning within the rehabilitation process was encouraged (p. 25).

Descriptions of the various methods utilized in the vocational evaluation process are readily available in the literature (Hursh, 1984; Hursh & Anthony, 1983; Pruitt, 1977; Wansborough, 1980). It is not our intent to provide textbook descriptions of situational evaluations or the commercially packaged work sample evaluation systems available as other writers have done this quite eloquently. Rather, the focus of this chapter will be on the experience of a particular hospital and community mental health center-based psychiatric rehabilitation service, the process of formal and informal assessment procedures, and the inherent problems and difficulties which are unique to the vocational evaluation of individuals who have major psychiatric illnesses.

THE PROCESS OF REFERRAL

The point at which the process of vocational assessment is initiated typically occurs well in advance of the initial intake interview between client and counselor. Upon receiving no more information than the client's name, whether via receipt of a formal referral form or an informal telephone call from the referring party, the counselor may begin the process of gathering information about the client which will constitute an integral part of the vocational assessment.

Use of the Medical Record

First, and of particular relevance to work in an acute care and community-based psychiatric setting, the clinician/counselor involved in vocational assessment, which is one aspect of a multidimensional, comprehensive treatment approach, should make use of data which is already collected and available. A secondary gain, which has derived from the attention given the client's medical record of late as a result of increasing demands for documentation and accountability by utilization review committees and various third party agencies, is the extensive information about the client which is available and relevant to vocational assessment. This information may, at a later date, expedite implementation of the rehabilitation plan. While some clinicians prefer to conduct the initial interview prior to reviewing information already on record, we would not recommend this approach for several reasons. First, one runs the risk of boring some clients or making them feel as though they are getting the runaround, i.e., that the clinician was not interested enough to have taken the time to prepare properly. This may only increase the frustration and pessimism that may already be present, damage the clinician's credibility with the client, and altogether, waste time which may be used more productively for the clinician and the client. Secondly, at the point in hospitalization that the client arrives for rehabilitation services, he or she usually will present an educational or an employment history in summary form, thus the clinician may receive only sketchy information from the client which will have very little utility in the long run. Of course, clinicians must be sensitive to the fact that information compiled in a client's medical record is subject to incompleteness, lack of contextual specificity, bias, and error, and exercise caution and judgment in the use of this data.

It is important, however, to remember that many clients are very sensitive with respect to what they regard as confidentially shared information about themselves. With highly guarded and/or suspicious clients, care should be exercised in approaching the topic of the client's past medical record or consultation with his/her physician or referring party. The clinician must point out to the client the need to clarify the request for service so that he/she has a general idea of why the client has been referred, and what the client is interested in. While the client may become angry or accusatory, feeling a trust has been betrayed, the counselor should not permit the client to put him or her on the defensive. It is a mistake to allow room for debate or argument on the clinician's "right" to relevant information. The clinician/counselor may reply that there are pieces of information about the client that are clearly relevant to vocational assessment and planning in order to provide the highest quality services possible. Should the client continue to take issue with this, it may be useful to deal with the reasons behind the client's obvious reluctance to share information, being careful not to put the individual on the defensive by saying, i.e., "What are you so afraid of?" Rather, the clinician should explore the reasons behind the anger and defensiveness and what implications this may have for future interactions. Also, it is important for the client to know with whom the clinician intends to share the contents of sessions, the clinician's role in the overall treatment process, and the clinician's responsibility to serve as a liaison with other professionals who may be involved in the client's treatment.

Communication with the Referring Party

Secondly, the referral process is an important linkage between rehabilitation services, acute care inclient units, and their respective outclient services. In keeping with the basic assumption that all rehabilitation endeavors are collaborative efforts and to insure continuity of care, referral apparatus and procedures should be well-established, efficient, and designed to enable quick and easy referral. We have found this to be of particular importance in an acute care facility and in any facility which also provides training and education to a variety of health care professionals and students with limited knowledge of rehabilitation services and their availability. Dispensing a supply of referral forms, providing a written, concise description of services; providing the names, locations, and phone numbers of clinicians who are available for consultation and questions; and building in a means for confirmation that the referral has been received and that the initial appointment has been scheduled are extremely important logistical procedures.

It is important to remember that the information gathered from the consultation/referral form cannot substitute for direct communication between the counselor and the referring party. A good time to speak directly with the referring party is after the counselor has had the opportunity to review all available information about the client and following the initial interview with the client. At this time it is best to: 1) clarify the request for services; 2) determine the priority that vocational rehabilitation services have in the client's overall treatment; 3) inquire into the client's current psychiatric status; and finally, 4) determine the approximate length of inpatient stay and disposition plans.

The timing of rehabilitation assessment/services must be synchronized with the treatment team plans. For example, the psychiatrist or primary clinician may have recommended to the client that he/she take six months at a minimum to recuperate from his/her hospitalization prior to actively pursuing vocational endeavors. (This is not an unusual occurrence with persons with schizophrenia and persons with severe depression.) Or, the referring inpatient clinician may make a very specific request, asking only for an assessment with concrete recommendations and short-term goals in order to insure that the client's follow-up clinician will be aware of the client's need for continued vocational rehabilitation services. Others may request documentation of intellectual capacity, aptitudes, and reading comprehension level in order to secure vocational rehabilitation funding which will enable the client to continue his/her college education or vocational training program without need for any additional services from the rehabilitation practitioner.

This time can also be used to inquire about any special precautions or remarks which may have been noted on the referral form, i.e., the client has a history of extreme hostility toward female therapists; is manipulative, demanding, or has a sense of entitlement; has a pattern of overloading or decompensates easily under stress. In some instances it may be necessary to communicate to the referring party that the referral seems premature and what may be done to better prepare the client for active involvement in vocational rehabilitation.

THE INITIAL INTERVIEW

Establishing Rapport

Goals for the initial interview include the following:

1) Establishment of rapport--"hooking the client in"
2) Initial formulation of the presenting problem(s) -- what is his/her problem and why does he/she have it
3) Initial formulation of the client's perception of his/her problems and how he/she prioritizes them
4) Clarification of the client's expectations of services and goals and, usually, clarification of services and intervention strategies available
5) History taking and information gathering
6) Initial determination of services and resources needed
7) Preparation for future assessment and assignment of tasks

These goals may need to be modified or narrowed and may vary depending on the nature of the consultation request. Moreover, the counselor should bear in mind that it may be impossible to achieve all of these goals in a single session. Factors such as: though blocking; tangentiality; extreme guardedness; suspiciousness; various neurovegetative symptoms of depression; attention deficits; memory and concentration difficulties; fatigue; preoccupation with other family or psychiatric concerns that may be paramount to the client at the moment; impending discharge; re-emergence of symptoms; or dissatisfaction with disposition plans may interfere with and necessitate modification in the process and pace of the initial interview.

The importance of the initial meeting between the client and counselor should never be underestimated or taken for granted. "Getting off on the right foot", particularly with outclients who are not going to be escorted to the office for future sessions, is an indispensable goal. Rapport is not merely a few introductory comments, a polite breaking the ice before getting down to the "nitty gritty" of history-taking and information gathering. Special care needs to be taken with clients who have a chronic illness or a long history of involvement with various human service agencies and professionals, but who have experienced minimal positive changes in the quality of their daily lives. Because these clients may frequently be only marginally successful in their attempts to achieve vocational success or maintain employment, they may be highly demoralized, pessimistic, and hopeless, having run the gamut from partial hospitalization programs to several trips through all of the local vocational rehabilitation training facilities. In some cases, the rehabilitation counselor may be the fourth or fifth specialized service professional that the client has seen already in one day!

Conversely, the client may be the fourth or fifth chronically ill and very needy client that the counselor has seen that day. The counselor/clinician needs to guard against writing such clients off because of a stereotypical image of them as unable to make decisions for themselves, helpless, confused, passive, unmotivated or uncooperative. The individual, on the contrary, may be highly suspicious and guarded and may be questioning the counselor's motives. Others may be highly defensive, needing and wanting assistance, while at the same time trying to bolster an already shaken self-image in order to maintain a sense of control over their own lives. Some clients may be in a state where symptoms are remitting but have not as yet cleared. They may be somewhat disorientated or confused from the side-effects of various medications (drowsiness, blurred vision, motor retardation/acceleration, or high distractability) that have just been initiated or have not yet reached a therapeutic level. Other chronically ill clients may suffer on a nearly continuous basis from various symptoms, such as distracting auditory hallucinations, chronic fatigue and low energy, anxiety, etc.

At the very least, at the time of the initial interview, the client is likely to be quite anxious and may feel very reluctant to share revealing personal information. There may be attempts to present the self in a favorable light through evasiveness around past history because of the client's sense of embarrassment or shame or as an effort to convince the counselor that he/she is worthwhile and therefore deserving of services. On the other hand, some clients may view the counselor as an obstacle between them and some desired vocational goal, someone they must convince or whose support is necessary in order to obtain vocational rehabilitation funding or a medical release from work in order to secure public welfare or Social Security benefits. Anxiety may also be due in part to the client's expectations of being "tested" immediately in some as yet unknown manner, coupled with the not uncommon expectation that his/her performance on these tests will have significant, far-reaching, and irreversible effects on the future. Some clients may then become angry or disappointed upon initially learning that they are not going to be tested immediately, particularly if they are counting heavily on tests to provide "solutions" or answers to their problems. Early on then, the counselor/clinician may need to assure the client that "testing" is likely to follow in future sessions.

During this initial interview, the counselor/clinician must communicate to the client a genuine concern for the client's well-being, respect for his/her integrity, and a desire to help him/her further desired goals. The counselor must demonstrate a willingness to listen and encourage clients to relate in their own manner. Care should be taken to follow-up on whatever issues the client chooses to share rather than attempting to rigidly adhere to the counselor's agenda. This may not be an easy task in light of the fact that many clients present with the general expectation of being examined, dissected, talked at and acted upon. In some instances clients seem to prefer this type of treatment, trusting that the "expert" knows best, unable or unwilling to accept responsibility for their own treatment decisions, or simply not knowing quite how to assume an active role in their own rehabilitation. Moreover, it is unlikely that such clients will be able to greatly modify such a stance in any hurry just because the counselor is informing them that their input and active participation are not only desirable but necessary. This is not to say, however, that the counselor need not be responsible for providing structure and direction for the interview. In fact, with clients who are highly agitated, whose speech rate is accelerated, tangential, or circumstantial, or with clients who volunteer little or no information, responding to direct questions with monosyllables or brief, unelaborated replies, the counselor may have to make greater efforts to control the pace and content of the interview.

Initial Formulation of the Presenting Problem

Generally, individuals who have been referred for vocational rehabilitation services have, at the very least, some uncertainty regarding their vocational future, and optimally, present with a desire to clarify questions about future plans and to learn more about their interests, abilities, and potential. The problems presented by individuals referred for vocational rehabilitation services may be divided into two broad categories: 1) a lack of career direction or goals because of insufficient information about themselves, their interests, abilities, and potential; and, 2) a lack of information about occupational possibilities and the availability of educational or training options to support a vocational goal.

These problems may arise from a wide variety of sources. The individual may have had little or no experience in the process of developing a realistic and feasible vocational goal because of little exposure to the world of work. For example, individuals who have suffered or are facing a severe financial reversal or loss of income and are faced with having to re-enter the job market after an extended absence, adolescents entering the job market for the first time, or individuals who previously functioned well in a vocational area but as a result of their psychiatric illness are not able to resume their former occupations will request guidance or direction in exploring satisfactory or alternative occupations, and, in some cases, meaningful and productive but avocational activities and options. Individuals with chronic or recurrent episodes of psychiatric illness may also have impaired vocational development because of an inability to maintain employment of longer than brief periods of time. Often individuals with personality disorders display character traits which contribute to ongoing difficulties at work, such as conflictual relationships and chronic dissatisfaction and frustration with their employment situation. At other times the clinician encounters individuals with certain personality disorders who change jobs and training programs rapidly, in a seemingly endless search for the "perfect" job.

Another area which is impaired by psychiatric illness and in which most clients evidence mild to severe deficits is that of job-seeking skills. Areas of common deficits include: the ability to seek and follow-up on sources of job leads, to present one's self in a positive light, and to answer "problem" questions on job interviews. To seek and obtain employment in today's highly competitive and complex job market is a challenging and taxing experience even for individuals without a psychiatric history or illness. For the individual with a psychiatric disability, this can be a terrifying and seemingly impossible task.

Initial Formulation of the Client's Perceptions of Problems

Often the client presents with multiple problems..."my only source of income, public assistance, will be cut off in three months...I need a job...but what I'd really like to do is go to auto mechanic's school because I enjoy working on cars and I'd be able to get a better paying job as well." It is essential in this initial interviewing phase to clarify the client's perception of his/her problems, and how he/she prioritizes them. Perhaps it will be necessary to delay the formal vocational assessment, in order to determine the feasibility of the longer range goal (auto mechanic's school), until the more immediate concerns of improving job seeking and interviewing skills have been addressed (loss of income in three months). At other times, the client may not perceive some things as problems, ... "I'm unemployed because the boss is a jerk...no one will give me a job", although, "the doctor said this would be good for me." The client's perception of his/her needs or problems must be clarified, as well as factors contributing to these perceptions.

Client's Goals and Expectations of Services

In attempting to clarify the client's request for services, the clinician cannot assume that the client has an adequate and clear understanding of why he/she has been referred or what services are available. More often than not, clients have only a general or rather vague idea..."I think I'm here for testing or some kind of job counseling." Other clients may have unrealistic expectations of services. Many clients arrive with the expectation that the counselor has a job waiting for them or will immediately refer them to a job. Some clients will expect the counselor to administer some tests, ask a lot of questions, and through some mysterious formula come up with "the right job" for them.

These common misconceptions will often necessitate a brief explanation of services, the counselor's role in overall treatment, and potential benefits for the client. How the counselor may be able to help with vocational or employment concerns must be presented in a meaningful and understandable manner. "Your doctor told me that you had to drop out of school after you became ill, but that you've been thinking about returning to college or perhaps getting into a secretarial training program, and that you were interested in exploring the possibilities...Generally, people come here who are interested in learning more about themselves, the kinds of jobs they might be best suited for...or who have questions about work or school...getting a job or going to school."

In instances where a vocational assessment has been specifically requested, and it will be the first phase in the individual's rehabilitation plan, the counselor must communicate the goal(s) and purposes of the assessment and how the individual may benefit from it. For example, "through this assessment you will gain some information about yourself -- your interests, abilities, aptitudes -- and information about the world of work, career choices, and training and educational programs, in order to help you answer questions you may have about your occupational future, and to make good decisions for yourself. We will try to help you find a good fit between your interests and abilities and the nature and requirements of different jobs."

Taking the Vocational History

At the time of the initial interview it is difficult to determine what information will be relevant or useful; thus, the counselor should explore in breadth, knowing that the most relevant information can be pursued in greater depth at a later time. This strategy provides the opportunity to assess the client's self-presentation and his/her perception of his/her difficulties and current situation. The clinician/counselor should note the client's reactions to questions about past educational and work experience. Hypersensitivity to criticism, suspiciousness of the counselor's motives for questions, and evasiveness about particular topics (such as reasons for job terminations or changes in jobs) may be evident and partially related to situational factors. For clients there is often a sense of being on trial, having to prove themselves worthy or a "good investment" in order to receive services, a sense of being judged on their track record. This may be very discouraging and frustrating for a client who has had no work history to speak of or a series of failures in attempts to complete training or hold a job.

The individual is being asked to reveal or share what he/she is likely to perceive as very personal and highly sensitive information about himself/herself. In this society, with the value and importance attached to work, one is often equated with what one does vocationally. The ability to work and achieve financial independence are considered to be hallmarks of maturity and adulthood. Clients may be all too keenly aware of deficits in these areas and often have very painful memories associated with school and work and the failure to achieve a highly desired goal. Other clients may leave out or downplay the negative aspects of their history in an attempt to present themselves in a very favorable light, to prove worthy of highly desired services. To attempt to assess motivation for comprehensive rehabilitation services on the basis of the initial interview and available background information is not possible and should not be attempted at this time. To do so would only mean ruling out a majority of referrals or potential clients, and is, moreover, contradictory to fundamental principles of rehabilitation.

Because clients are often poor historians and symptoms frequently interfere with the interviewing process -- thought-blocking, tangential/circumstantial speech, anxiety, distractibility, drowsiness secondary to medication -- the counselor should not be in a hurry to force the interview to completion. The initial interview may not be completed in one setting. Some clients sometimes ask to end the session early, or with some clients, such as those still in the active phase of a manic episode, the counselor may have to exercise more control over the content, structure and time limits of the discussion. It is important to remember that educational and employment-related history taking and information gathering consist of much more than recording basic facts -- names, dates, places. With the psychiatrically disabled client, the realm of relevant information is much more broad than with the physically disabled client. Attention must be given to the less tangible but equally important aspects of previous educational or vocational experiences, such as involvement, career maturity, worker attitudes and behaviors.

Work personality, as defined by Gellman (1967), is "...the characteristic pattern of work activity displayed by a person in a work situation. The work personality incorporates work attitudes, behavioral work patterns, value systems, incentives and abilities. It is the behavioral configuration regarded as necessary to function effectively in a work setting." (p. 283) Adjustment to a work environment includes not only task mastery, competencies and skills, but social functioning and characteristics of the environment. For instance, persons with mental illness often experience difficulty in detecting and staging within the covert, unwritten behavioral and attitudinal "norms" which operate in all work settings. Obtaining information which enables the evaluation of specific and general employability factors should yield a profile of characteristics relevant to career planning for use in the later stages of vocational counseling and career planning. Finally, as always with persons with psychiatric disabilities, history taking must include a description of assets, demonstrated skills and abilities and strengths which can be utilized and built upon, not just the client's failures, deficits or liabilities.

Employment Data

The history taking process should include, but may not be limited to, the following

- what were job duties and responsibilities;
- how were jobs obtained--independently, through a friend or relative, etc.;
- were formal interviews required in order to obtain jobs;
- where were jobs located;
- what factors influenced decisions to accept jobs and to leave jobs;
- how long did jobs last;
- what aspects of jobs were initially attractive to the client; which were problematic; which were gratifying;
- what kinds of situations were faced on jobs--routine procedures or continual changes in duties and responsibilities;
- what situations were easier or more difficult for the client to handle;
- what were sources of satisfaction and dissatisfaction on jobs;
- what aspects of jobs did the client find stressful;
- was the stress occasional or on a nearly continuous basis;
- what were the means of coping with stress and dealing with difficult situations;
- what were the client's initial expectations of jobs and did these coincide with the actual jobs themselves;
- what degree of social contact or interaction was required on jobs;
- were complex, higher level social skills required, i.e., persuasiveness, negotiating, compromising, supervising, coordinating, planning;
- which did the client prefer, dislike, or find difficult.

A broad yet comprehensive exploration of the client's employment history provides information which the client and counselor can draw upon in order to address concerns over pending career or vocational decisions. For example, one client who functioned very well as a janitor on a solitary night shift, contemplated changing to a similar job on a daylight shift because it would provide a better income. However, he was concerned about whether this would be advantageous because it would require substantial changes in non-technical aspects of work performance and he was uncertain as to how this might affect his job performance. Specifically, the daylight job required increased contact with co-workers, closer proximity to supervisors, more frequent public contact, and stricter adherence to a dress code. By examining his history of meeting similar demands in past employment endeavors, the client was able to make a more informed decision about whether or not to transfer to the daylight job.

While clarifying the client's employment history, it is important to explore both the objective and subjective reasons given for the termination of specific employment endeavors. Clients are often reluctant to explore details surrounding negative employment terminations. Nevertheless, this aspect of clarifying the employment history is not to be avoided and should be approached with sensitivity. This type of exploration is critical because the events most clearly related to termination are usually not the result of an isolated or abrupt incident. The identification of the factors which contributed to job loss or losses can be identified and either remediated and/or taken into account in vocational decision making. Quite often, an individual's job losses have been related to difficulties in meeting the social demands of work; these difficulties are often described by the client as simply a matter of experiencing one or more "personality conflicts" with co-workers, supervisors and/or employers. Frequently, clients lack an understanding of what a "good working relationship" with respect to their co-workers means, and experience difficulties in maintaining such or in maintaining boundaries. This lack of knowledge regarding how to maintain effective working relationships can manifest itself in a variety of ways. For example, a client was continuously cited by his boss for socializing or talking too much on the job and at improper times. A second client, in an attempt to maintain a total separation between his work and personal life, created extra distance between himself and his co-workers by telling them that his hands were classified as "lethal weapons." Others relate fairly well with co-workers but experience problems with authority figures such as supervisors and resent being told what to do.

Self-Appraisal and the Meaning of Work

It is also important to explore the client's perception of his/her own work performance, a self-appraisal of his/her abilities, skills, and general worker characteristics, and the sources, both internal and external (corroborating information, indicators of performance such as raises, promotions, length of employment, etc.), of his/her self-evaluation. One client described herself as "I can do it all." She had had a job as a secretary/bookkeeper and all-around office worker for a small family-owned plumbing business. She had aspired to a position as business manager and felt the only obstacle in her way was the lack of a formal degree. She revealed that she had been unable to complete the first college-level business course she had attempted 3 years earlier. Her MMPI profile was similar to individuals who were described as having a decompensating obsessive-compulsive disorder and she was hospitalized with complaints of depression. It was important then to ascertain the client's perception of her failure to hold her job and of the difficulty she experienced in achieving a desired goal. A client's acceptance of any limitations imposed by a psychiatric illness, particularly tolerance for stress, while not easily defined, is usually a very significant factor in any given client's self-appraisal.

The need to assess the meaning and value of work to the client, presently and in the past, is also essential. What needs does the client expect that work will fulfill--financial independence, material comfort, security, "something to occupy my time, keep me busy", meeting new people or fulfilling social needs, recognition, feeling productive, or as something to do to avoid negative consequences? The client's perception of locus of control, his/her own ability to effect a vocational future, exert influence, or make changes vs. a belief in fate, chance, a religious deity, or other uncontrollable influences gives a sense of the client's optimism regarding his/her vocational future and whether he/she perceives that efforts will "pay off"; that is, result in any real, concrete, and positive changes in the quality of his/her life.

The counselor should also inquire into any previous exposure or involvement with vocational counseling that the client may have had, and whether these were positive and helpful experiences or nonproductive and demoralizing experiences, and why. Many clients with chronic illnesses have received vocational rehabilitation services on more than one occasion in the past, and may have undergone previous vocational assessment, work evaluations and/or personal work adjustment training. While care must be taken not to accept the results of previous assessments at face value as the client may have been entering an active phase of illness or experiencing an acute life stressor at the time of the evaluation, it is a good idea to investigate the extent and kinds of services previously provided not only to prevent duplication of services but also to complement the usefulness of such prior services and to reduce the likelihood of splitting.

Social and Environmental Factors

The counselor needs also to determine what sources of income are available to the client and any financial obligations he or she may have. Often for clients there are possible disincentives to work. After a 10 year psychiatric history, during which the client has received SSDI benefits, it is likely that he/she may be unwilling to jeopardize his/her status by earning more than $200.00 per month. Most clients (and many professionals) do not have a clear understanding of SSI and SSDI and have in common the misconception that one cannot earn any money at all and continue to receive benefits. Such financial concerns seem to have greater significance for clients than often is recognized by rehabilitation professionals. It may not be in a client's best interest to pursue gainful employment, and yet this seems difficult for some counselors to accept as these clients will not be considered a "successful closure" by state vocational rehabilitation agencies. When clients are on SSDI, Veteran's Disability, or private insurance disability payments they tend to perceive the risks as even greater. It seems that clients have little or no belief in the "nine month trial work period" which is supposed to serve as an incentive; some may not even by aware of it. Their skeptical stance is somewhat justified in light of the near superhuman efforts required to obtain benefits in the first place, including making the client appear as "sick" or disabled as possible on the part of their primary clinician.

Loss of other related benefits (subsidized rent and housing programs, eligibility for energy/utility assistance, reduced transportation costs, medical assistance) is also an important consideration to clients, particularly if they have had multiple hospitalizations and fear recurrence of illness. The middle-aged or elderly who fear worsening physical health problems have a difficult time understanding that they cannot be denied needed medical care on the basis of an inability to pay for services.

Whether or not the client has a supportive family or other family-like support systems is a relevant concern during the initial data gathering period. Some families may be intolerant of the client, feeling themselves drained both financially and emotionally and may be exerting great pressure on the client to recover from his/her illness and resume a breadwinner role. Some who live at home may experience an atmosphere which is not conducive to rehabilitation efforts. It may be noisy, crowded, or highly conflictual. Is there a place and time to study, are there daycare arrangements for children, is educational achievement or having a legitimate means of support included in the family's values? Other clients may be relatively isolated and lacking in family supports. In these instances their involvement with other social and human service agencies is important to assess. While for still others, religious involvement or social group involvement, such as a leisure learning dance class, are extremely important activities. One client would not consider attending group therapy meetings because they were offered at the same time as his bowling league--a source of achievement, recognition, and satisfaction for the client.

Assessing the client's daily routine and use of leisure time can yield information for future vocational planning. One can learn much just from the client's sleep schedule for example. It is not uncommon for clients to sleep during the greater part of the daytime and remain awake the greater part of the night as a means of titrating stress or avoiding the stress of having to deal with other people. One client continued to express the desire for a job, yet was unable to modify his current sleeping schedule of 5:00 a.m. to 5:00 p.m., which effectively ruled out even applying for employment.

Educational Background

A client's previous educational experiences will have, in many cases, a real influence on future training or educational programs that may be planned as part of the rehabilitation process. Whether or not the client was in regular or special education classes, the client's reaction to failed grades, particularly difficult classes or easier classes, should be explored. One client, for example, was held back in the second grade which put him in the same class as his younger, more successful brother. He considered this to be a very significant event and decided not to compete with this brother in anything from then on. At the age of 23, he continued to use this event as a reason for not completing any of several, successive training programs.

Further discussion should center on the client's high school curriculum, whether it had an academic, vocational skill, or a general business preparatory focus. How did the client feel about being a student? What were his/her relationships with teachers and authorities; how adequate were his/her study habits, were there any marked changes in grades or school attendance (why and in response to what)? Did a particular teacher or anyone else serve as a positive role model or mentor with special influence on the client? How involved was he/she in sports or other extracurricular activities? What was the quality of his/her social and peer relationships? If the client dropped out of school, what were the precipitating factors, and the family's attitude toward this? Were there any attempts at further education or training since leaving high school? How were they financed? The issue of previous arrangements in order to finance schooling is particularly important with regard to defaulted student loans, as it may mean that the client is ineligible for further financial aid for new training or education in the future, or that he/she may be eligible for rehabilitation deferment on current student loans.

What is the client's attitude toward additional training or education at this time or in the near future? The counselor needs to begin to assess the client's ability to tolerate the structure and demands of school, and if schooling can occur only on a part-time basis, which lengthens training time, can the client sustain motivation for this longer period and would the family be tolerant of this?

Medical, Psychiatric and Psychological Background Information

While most of this information should be available in the client's medical record, what are of primary importance to the counselor are any functional limitations which may impair the client's ability to perform certain kinds of activities, and whether treatment or intervention can remedy some or all of the functional impairments. The counselor needs to be aware of whether the condition is progressive or can be controlled with ongoing treatment, the client's acceptance or non-acceptance of these limitations, and whether refusal to accept limitations serves a defensive/protective function for the client.

As with the medical history, the client's psychiatric history is usually well-documented in the medical record. Here the counselor should be aware of the chronicity of the illness, and whether there is likely to be a need for rehospitalization in the future. What were the precipitating factors and what are current stressors, and what is the client's attitude toward and acceptance of the need for treatment, including medication? How the client's illness or symptoms have interfered with independent living or vocational goals, have disrupted relationships or the ability to get and keep employment, or have affected the ability to complete educational or training programs in the past need to be assessed.

Moreover, other psychological testing is frequently available in the medical record and as part of the holistic treatment approach, psychometric, objective tests can yield information relevant to preliminary planning and future career planning. Neuropsychological tests may suggest strategies to be employed or methods to be used in teaching or learning for the client with implications for the training environment. (See Chapter II for a more in-depth discussion of the use of psychological and neuropsychological assessment procedures in rehabilitation planning.)

PREPARATION FOR FORMAL TESTING

Once the gathering and evaluation of historical and current situational data is well on its way, it may be necessary to introduce the idea of formal testing as part of the vocational rehabilitation process. Again, the element of timing is critical. Optimally this should occur when the client presents with the desire to learn more about him/herself with regard to formulating career plans or goals. The client must be sufficiently engaged and willing to invest him/herself in formal psychometric testing. Since symptomatology may interfere with the testing process, it is wise to avoid testing while the client is in the acute phase of his/her illness. It may be necessary to inquire into such factors as to whether the client has been in the hospital long enough to adjust to the hospital routine and is sufficiently integrated into the therapeutic milieu, has gotten sufficient relief from painful or disturbing symptoms, and whether, in his/her opinion, high priority concerns have been addressed or assurances have been given that these will be worked on, thereby permitting the client to invest him/herself in vocational testing.

Frequently, it becomes necessary to deal with the fact that many clients are unfamiliar with test-taking situations, may not understand the purposes for testing, or may not be able to see any potential benefits to themselves from the testing process. Adults who have been long out of school and who are not test-wise are often overly concerned with accuracy at the expense of speed which can then result in poor total performance scores.

For others, since paper and pencil tests are seen as similar to classroom tests, they are often associated with a history of failure and negative experiences. Other clients may have had limited experience with tests. Pre-testing orientation exercises may be useful for some clients to help decrease anxiety and increase confidence in their ability to take tests.

The client should understand why the test is being given, the kinds of information it will yield, and how this information will be useful in vocational planning. Letting the client know that the results will be reviewed and interpreted with him/her is also helpful. Clients often view tests as "for the doctors" and expect that they themselves will never see the results. Establishing the relevancy of vocational test results to later educational and training options and potential career direction also helps to decrease anxiety, increase understanding and, consequently, motivation for investment in testing.

In reviewing the relevance of vocational testing, the counselor should emphasize that results from the overall testing process are more inclusive than any single component of testing, and that while each test plays a useful and contributory part in the overall process, testing of various kinds is still only one aspect of career decision-making. This type of information can help remove the threat of forfeiting a desired outcome--a job or eligibility for further services--for the client who fears poor scores will result in such exclusion. In general it is important to let the client know how the assessment will proceed, what kinds of tests will be administered, and approximately how long the procedure will take. While such small details may seem unimportant to counselors, they are often highly important to clients who may wish to know when to prepare themselves for testing.

Finally, it is usually necessary at times to ascertain a client's reading comprehension level to aid in test battery selection. Age and years of education completed are not always valid indicators in and of themselves. The Wide Range Achievement Test-Revised (WRAT-R) (Jastak & Wilkinson, 1984) is a reliable and easy to administer measure for screening purposes. However, since only reading recognition is measured on the WRAT-R, a measure of reading comprehension is indicated. This is important because most vocational tests are written on a sixth grade reading comprehension level. In some cases, the counselor may need to use a non-reading battery or may opt to read test items aloud.

Counselors are responsible for being familiar with the APA standards for test users as well as standards for tests, manuals, and reports in the book Standards for Educational and Psychological Tests (1974) and should know the tests intimately. It is also the counselor's responsibility to establish conditions which will enable each examinee to do his/her best, above and beyond the standard testing conditions, i.e., noise level, light, ventilation, room temperature, seating arrangements for group administration. Where it is permissible to do so, the counselor may need to modify standard administration procedures when working with psychiatric clients who may be highly distractible, may exhibit psychomotor agitation or retardation, may experience thought blocking or word finding difficulty, may tire quickly, or who may have difficulty in comprehending, and particularly, remembering test instructions. It may be necessary to (1) repeat instructions; (2) provide further clarification; (3) shorten the testing session or provide frequent breaks; (4) provide verbal redirection to tasks; (5) control the pace of test administration (slowing it down for impulsive responders); or (6) decrease the client's level of anxiety by appropriate modulation of voice tone and rate. The counselor's presentation and behavior during test administration can significantly influence the quality, reliability, and validity of test results. While, after reviewing test instructions with the client, counselors may be tempted to permit clients to take certain kinds of vocational instruments (occupational interest inventories like the California Occupational Preference System (Knapp & Knapp, 1974, 1982) or the Edwards Personal Preference Schedule, (Edwards, 1953, 1959) out of the counselor's office and on to the inpatient unit or home with them, it has been our experience that caution should be exercised with this practice as often the counselor will have to deal with misunderstood instructions or the lack of internal consistency with the same instrument completed in multiple sittings.

Behavioral Observations

It is essential that counselors be proficient and efficient with testing procedures so that attention may be given to the very important observations of the client's behavior and responses during testing. The client's reactions during testing may be considered a sample of that individual's behavior or response set toward evaluative and/or demanding activities and stress. Also, the client's overall performance must be considered in light of such conditions. Counselors may find it helpful to employ a separate checklist of behavioral observations with enough space to jot down significant observations. Factors which should be noted include the following:

- Affect: broad, within normal limits, flat, constricted, labile, angry, blunted;
- Mood: euthymic, dysphoric, euphoric;
- Attention/Concentration: distractible, marginally engaged, need for redirection to task, sustained;
- Level of Anxiety: mild and appropriate, moderate, severe, hypervigilant, scanning;
- Blocking: interrupted train of speech before thought/idea is completed;
- Psychomotor Agitation/Retardation: excessive motor activity associated with inner tension, restlessness, visible slowing down of

physical reactions/movements;

- Speech: circumstantial, indirect and delayed in reaching the point, pressured/accelerated, loosening of associations, perseverative, self-deprecatory or excusing one's poor performance;
- Cooperation: defensive, guarded, hostile, suspicious, passive, submitting, eager, willing, challenged, invested, interested, fearful, timid;
- Response Style: impulsive; jumping ahead in directions to example problems; greater concern with speed than accuracy; concern just to complete a test;
- Tolerance for Frustration: gives up easily in face of difficulty, persists till the end of time allotted, uses remaining time to check back over work, randomly responds to items, refuses to even attempt certain tasks, responds to encouragement;
- Response to Obvious Failures: concern with "doing it right", requests for feedback, obsessiveness, erasures, corrections, attempts to explain his/her performance, discounts the importance of the test, attempts to discredit its worth or validity;
- Rapport: easily established, never quite achieved, adequate for testing.

Pre-Testing Orientation Instruments

The Test Orientation Procedures (TOP) (Bennett & Doppelt, 1967) may be used as a preface to any kind of vocational assessment or testing in an effort to decrease anxiety and increase "test wiseness" by offering practice in taking tests. It can be administered individually or in a group setting with taped instructions and explanations. Designed to be used in a thirty minute session, the TOP consists of easy, test-like exercises in a 20 page practice booklet (a second one is also available for take-home practice) with five tests for speed and accuracy, spelling, vocabulary, arithmetic, and general information.

The USES Pretesting Orientation Exercises (U.S. Department of Labor, 1947-1983) is a mini-test battery of the first 8 parts of the General Aptitude Test Battery (GATB) (U.S. Department of Labor, 1947). While a one and one-half hour administration time is needed, the exercises are flexible enough so that they can be shortened for individuals who need only a refresher orientation to the tests.

THE TEST BATTERY

Formal assessment and the objective information yielded by psychometric techniques can serve as a "reality tester" for clients allowing individuals to test their assumptions, self-perceptions and appraisals against standardized test results [illegible]bjective information.

Formal assessment is an integral, and frequently an indispensable component in the process of assisting clients in making sound vocational choices and in developing realistic vocational goals. Among the psychiatrically disabled, it is not uncommon for a client to view his/her own strengths and abilities in a somewhat distorted manner. An individual may hold either a self-deprecating or aggrandized view of his/her own abilities. This is true of adolescent clients in particular, as illustrated in a study by Briscoe, Meulder, and Michael (1981) which examined the degree of the relationship between objective scores on each of the nine standardized ability measures included in the General Aptitude Test Battery and the self-estimates by a sample of 258 high school students of their level of ability in each of the same aptitude areas. The study's authors concluded:

> "With the possible exception of skills involving motor coordination, finger dexterity, and manual dexterity, adolescents irrespective of age level appear unable to provide valid self-estimates of their abilities, at least with respect to criteria provided by standardized test measures reflecting the same abilities."(p. 1293)

Test selection should always be done on an individual basis and should be based on a prior determination of what kind of information is desired and why. Vocational assessment should yield a profile of characteristics that are relevant to career decision-making which will help to generate a vocational direction, goal or plan.

The typical formal vocational assessment battery for which the rehabilitation counselor has primary responsibility will usually include measures of academic achievement, interest, aptitude, work values, personal preferences and needs. The following section will provide a brief description of a typical battery with the kind of information it yields, the limitations thereof, reading level required, and a brief note on administration and scoring. (Note: as achievement testing has been addressed at length in another Chapter, it will not be included in the present discussion.)

INTEREST TESTING

Interest tests are usually the first tests to be administered to clients as they are generally non-threatening, stimulate the client's interest and motivation, facilitate communication, and usually have very clear meaning to the client (high face validity) as their purpose is readily apparent. Interest tests are a useful tool in the process of vocational exploration for a number of reasons. First, they can be used to delineate occupational areas of high interest which will be fruitful for further exploration or to broaden the scope of occupations under consideration. Often a client may have few if any expressed areas of interest; others may feel incapable or hopeless about the future, lacking even fantasies or daydreams. With clients who have been unable to perform successfully on several dif[illegible]t kinds of jobs, there is often a feeling that there is nothing out there for them that may be of interest. Increasing the number of vocational options is especially important for youth with no work experience or exposure and for adults, who through disablement, are no longer able to pursue their former occupation and are feeling at a loss as to where to turn. Conversely, interest tests may be useful in narrowing down the range of occupations under consideration, focusing more specifically on areas of elevated interest, and may be useful with individuals who claim to be interested in "everything," with perhaps little knowledge of actually what specific occupations may entail. Finally, interest tests are useful as a counseling tool, providing a good basis for discussion of the specific likes and dislikes the individual has about a particular occupational choice.

SPECIFIC INTEREST MEASURES

The AAMD Becker Reading-Free Vocational Interest Inventory, Revised (R-FVII) (Becker, 1981) is a non-reading vocational preference test for use with mentally retarded and learning disabled persons from the age of 13 to adulthood The R-FVII furnishes information on a wide range of occupations and job tasks at the unskilled, semi-skilled, and skilled levels, presenting illustrations of individuals engaged in clearly illustrated job tasks. Using forced-choice format for selection (155 triads), examinees are instructed to select the one task they would like to do most. The Inventory yields scores in 11 interest areas for both males and females--Automotive, Building Trades, Clerical, Animal Care, Food Service, Client Care, Housekeeping, Personal Service, Laundry Service, and Materials Handling. It is a self-administering instrument with no time limits taking approximately 20 minutes to complete. The consumable booklets are hand-scored and individual profiles yield raw scores, conversion (T-scores), percentile ranks and stanines for interpretive purposes. Norms are available for public school grades 7 through 12, both EMR and LD males and females; adult mentally retarded individuals, based on samples from sheltered workshops and vocational training centers. It is a useful tool when there is a need for a non-reading measure of occupational interest with LD clients and clients who cannot be administered the California Occupational Preference System (COPS) (Knapp and Knapp,1974, 1982) or the Strong-Campbell Interest Inventory (SCII) (Strong, Campbell & Hansen, 1933, 1985) because their reading level is below a 6th grade level.

The Vocational Interest Profile Report (VIP), Rainwater, (1983) , based on the Interest Checklist (U.S. Department of Labor, 1979), was designed to help identify areas of occupational interest. The test authors claim that it is especially useful with individuals with no definite work interests and with those who are not aware of the variety of jobs and occupational fields that exist. The VIP consists of 210 items which relate to work activities, selected to reflect a sampling of jobs found in twelve major work categories, divided into 66 subcategories, which are described in the Guide for Occupational Exploration (G.O.E.) (U.S. Department of Labor, 1979). The VIP and its resultant report are designed for use with USES Guide for Occupational Exploration (G.O.E.), which contains all occupations found in the 4th Edition (Revised) of the Dictionary of Occupational Titles (D.O.T.) (U.S. Department of Labor, 1991), except for military occupations. There are two methods of administration, a paper and pencil format with answers entered into a computer, or administration by computer with the counselor present to explain operating instructions. This method requires an IBM Personal Computer or an IBMPC compatible computer with at least 128K of RAM, with one/more disk drives; a DOS (disk operating system), a version of 1.10 or 2.00; a serial/parallel interface printer; and a monitor. The test comes with a five page booklet of instructions and four screens of instructions which can be retrieved at any time. The 210 items are presented in question form, with three possible answers -- like, uncertain, dislike. The result is a 6 to 10 page report with five sections: 1) demographic; 2) introduction to the report; 3) a list of all twelve interest categories ranked by percentiles representing the percent of the weighted score compared to the total possible weighted score for each category; 4) a listing of all the individual items answered (L,U,D); and 5) a narrative description of the top three interest areas in terms of the G.O.E. Interest Categories. These are divided into subcategories which are described. Examples of jobs within each area are provided along with corresponding D.O.T. titles and numbers. Lastly, the reader is referred to sources of additional information, the D.O.T. and the G.O.E. Advantages of the VIP are the user-friendly aspects of the program, the brief time required for administration, immediately available results for review and feedback, and printout(s) available for independent vocational exploration by the counselee. The disadvantages includes the inclusion of occupations which are unrealistic in terms of the job market and which then detract from the face validity of the report for the consumer.

The California Occupational Preference System Interest Inventory (COPS) (Knapp & Knapp, 1974, 1982), is an interest inventory that provides job activity interest scores related to occupational clusters keyed to curriculum choices and two major sources of job information, the D.O.T. and the Occupational Outlook Handbook (O.O.H.) (U.S. Department of Labor, 1990). Written on a sixth through eighth grade vocabulary level, there are 168 items describing activities performed in a wide variety of occupations with a 4-point response scale--like very much, like moderately, dislike moderately, and dislike very much. The profile of the client's likes and dislikes is based on the assumption that people tend to excel, or at least devote more energy to activities they like. Scores are obtained for 14 scales representing clusters of occupations at two levels, professional and skilled, within five major occupational areas. The authors claim that the occupational clusters group together those occupations which are most similar in terms of activity preference, i.e., "surgeon" is not grouped with medical record librarian under "health" but rather under the Professional Science and Written Communications occupational clusters respectively.

Professional occupations typically require college training and/or advanced degrees and are characterized by a high degree of autonomy and responsibility with stringent personal qualifications of aptitude and personality to be met. With the skilled occupations, specialized training is usually required from the trade school level to the associate degree level. These jobs demand less responsibility and offer less autonomy. The COPS may be used from grade 8 through adulthood and is said to be of equal assistance to the vocationally oriented, non-college student, as well as the professionally oriented, college bound student. A plotted interest profile shows the student's relative standing in each occupational cluster as compared with the occupational interests of other students, at the high school and community college level.The COPS-P, or Professional-level interest inventory, is intended more specifically for those interested in higher level, professional occupations/careers and the college-bound.

Administration time takes twenty minutes as does self-scoring; however, the manual does not specify a reading level for the self-contained interpretive booklet. Because of the personal involvement of the examinee in both administration and scoring, an expanded awareness of the measurement process occurs which is then reinforced by the immediate feedback of the results.

The Self-Interpretation Profile and Guide of the COPS provides a general description of each occupational cluster, specific sample occupations within each cluster, related courses of study, possible college majors, some specific skills and abilities needed in these jobs, and suggested activities in which to gain experience. Each occupational title is keyed to either the D.O.T. or O.O.H., major sources of occupational information, and the COP System Career Cluster Booklets, also available from the publisher. In addition, the manual provides an appendix containing an explanation of the D.O.T.'s Data, People, Things digit coding system. It is important to keep in mind, however, that information provided on construct and concurrent validity is weak and vague, there is little information available on predictive validity, and specific information about the nature of the norm groups is limited.

The Strong Campbell Interest Inventory, Revised, Form T325 (SCII) (Strong, Campbell & Hansen, 1985) compares a person's interests to those of people happily and successfully employed in a wide variety of occupations. It employs 325 items to inquire about a respondent's interest in a wide range of occupations, occupational activities, hobbies, leisure activities, school subjects, and types of people. Thus, it gives persons information about themselves and what will help them make decisions about their life plans, permitting counselors to discuss broad themes in addition to specific occupations. The SCII consists of seven parts which yield scores on 6 General Occupational Themes based on Holland's typology (Holland, 1973) which reflect overall occupational orientation, 23 Basic Interest Scales, which report consistency of interests or aversions in 23 specific areas and 107 Occupational Scales, which indicate degree of similarity between the respondents's interests and the interests of persons in a wide range of occupations. Additionally, the SCII yields a measure of introversion - extroversion and degree of comfort in an academic environment. Invalid or unusual profiles may be identified through the 26 Administrative Indexes provided. The User's Guide for SVIB-SCII (Hansen, 1984) is available to counselors to facilitate the interpretive process.

The SCII requires thirty minutes for administration, a 6th grade reading level, and has been found to be most beneficial with persons over 17 years of age, the point at which interests begin to solidify for most people. Moreover, the inventories must be machine scored. With regard to individuals with schizophrenia, however, it is important to note the following statements from among the conclusions of the Final Report of the Vocational Assessment Project, 1979-1980 (New Jersey State Department of Education, Trenton Division of Vocational Education, 1980):

> "For most schizophrenic clients, the SCII does not discriminate occupational interest patterns. For this reason, its use is not recommended." (p.110)..."The intercorrelations among the general occupational themes are high, ranging from .44 to .80. This probably means that there was very little interest patterning on the SCII for schizophrenic clients (n=63). Profiles tend to be flat, indicating a lack of differentiation of interests with many responding like or dislike to most questions on the inventory" (p. 60).

APTITUDE TESTING

Aptitude tests are designed to measure the capacity of an individual to learn and/or develop proficiency in a particular endeavor, assuming appropriate training is provided. Achievement tests, on the other hand, are intended to measure how much a person has learned in information and skills as a result of previous education and/or training. In actuality, the two are intercorrelated quite highly. Aptitude tests provide an objective method of identifying strengths and deficit areas in individuals who are uncertain about their own capabilities as they relate to particular academic and vocational pursuits. They are also of value with clients who may hold either a very aggrandized or self-derogatory view of their own capabilities.

The Career Ability Placement Survey (CAPS) (Knapp & Knapp, 1981) was developed to meet the need for a brief measure of abilities related to occupations and careers. A major goal for its development was to provide a battery yielding the greatest interpretive usefulness per unit of testing time, which resulted in the development of eight five-minute ability tests. The aptitude areas measured include: Mechanical Reasoning, Spatial Relations, Verbal Ability, Numerical Ability, Word Knowledge, Language Usage, Perceptual Speed and Accuracy, and Manual Speed and Dexterity. Total administration time is approximately 51 minutes, and when used in conjunction with the Career Occupational Preference System of career clusters, provides an individual with a profile or picture of his/her abilities in terms of these occupational clusters. The format includes one-page, non-reusable booklets with instructions and example problems on the front side, test items on the reverse side. Tests are hand-scorable, with machine scoring available, and may be scored by the examinees themselves.

Scores on the CAPS are meant to reflect relative ability in eight major ability dimensions and may be interpreted in two ways; profiles in the form of stanines and a CAPS profile which involves various combinations of stanine scores keyed to the COPS system of occupational clusters. The authors claim that each cluster score is based on a combination of individual ability stanine scores, representing those dimensions which, historically, have been shown to yield the greatest predictive validity for success in jobs in each cluster. In determining the ability requirements of jobs within a given cluster, validity indices for tests measuring abilities corresponding to those measured by the CAPS test were obtained from a number of sources, including the General Aptitude Test Battery (GATB) (U. S. Department of Labor, 1947-83), the Employee Aptitude Survey Technical Report (Ruch & Ruch, 1963), and the worker trait components of the D.O.T. (U.S. Department of Labor 1977). Judgments were then made as to which CAPS ability dimensions were most relevant to the requirements of the majority of jobs in each occupational cluster. Norms are available for grades 8 through 12 and community college level. Norms for adult psychiatric clients are also available, although in general, these do not differ greatly from the national norms (Katz, Goldstein, Geckle, Morrissey & Daily, 1991). Additionally, the CAPS offers certain psychometric, administrative and clinical advantages over the more commonly used GATB described below (Katz, Beers, Geckle & Goldstein, 1989).

The General Aptitude Test Battery (GATB) (U. S. Department of Labor, 1947-91) was designed to assess vocationally significant aptitudes useful in vocational counseling, job selection, and job placement. The GATB consists of twelve subtests measuring nine aptitudes: General Learning Ability, Verbal, Numerical, and Spatial Aptitude, Form Perception, Clerical Perception, Motor Coordination, Finger Dexterity, and Manual Dexterity. Scores are presented as standard scores, with a mean of 100 and SD of 20. Screening criteria for the GATB include a 6th grade reading level, examinees preferably between the ages of 16 and 54; without defects in hearing, visual impairment, or use of the hands or arms; and the ability to stand independently for the manual portions of the test.

Formal training for test administrators is required prior to release of testing material. The GATB is available in two forms and was designed as a group test which requires 2.5 hours of administration time and approximately 30 minutes to hand score, although machine-scoring is available. Scores are converted into nine aptitude scores which are compared to requirements for specific job areas, Occupational Aptitude Patterns (OAPs), or to specific job requirements, Specific Aptitude Test Batteries (SATBs), where applicable. Performance on the OAPs is interpreted in terms of High (H), Medium (M), or Low (L) scores on the 66 OAPs. The 66 OAPs, covering more than 1200 occupations, are combinations of aptitudes with associated cutting scores for groups of occupations.

An OAP may be defined as "The combination of aptitudes and minimum scores required to perform satisfactorily the major tasks of each occupation identified with each pattern." OAP scores should be considered as guidelines, not cutoff scores. Each OAP is scored as either High (the examinee's scores met or exceeded those of workers judged to be satisfactory in a particular occupation), Medium (examinee's scores came within one standard deviation of those workers judged to be satisfactory), or Low (examinee's scores were more than one standard deviation below those of workers judged to be satisfactory in a particular occupation). There are over 400 SATBs, which are combinations of two, three, or four aptitudes with associated cutting scores for specific occupations, to which an individual examinee's scores may be compared as well.

The GATB was originally normed in 1952 on 4000 workers representing a random sample of the "general working population." All samples are clearly and accurately defined. The manual provides extensive information on reliability and the GATB's validity is one of its strong points, having been validated in over 450 separate jobs. It is probably the best validated test of this type available. However, according to the Reviewer in Buros (1972), the battery runs the risk of becoming obsolete, since much of the validation research has been on semi-skilled occupations and not on technical jobs, and the method of validation has not changed. In addition, with specific reference to the use of the GATB with the psychiatrically disabled, the New Jersey State Department of Education (1980) conducted a study in an effort to improve the vocational rehabilitation programs for persons with schizophrenia by designing an effective vocational assessment phase. The inactive records of 120 schizophrenic clients at 3 sheltered workshops in New Jersey, for whom 91 GATB profiles were available, were examined to determine the validity and reliability of the assessment instruments being used. The study's authors concluded:

> "Although age and years of education between the schizophrenic sample and the general population were comparable, the mean scores on all GATB subtests were lower for the schizophrenic sample compared to the general population. The largest difference between schizophrenics and normals

> were on parts 9, 10, 11, and 12. This comparison indicates that the schizophrenic clients performed poorly on all parts of the GATB, particularly those which involve manual and finger dexterity." (p 84)..."It is recommended that the GATB be used with extreme caution since it seems to have limited construct validity. It probably underestimates the aptitude of schizophrenic clients." (p.110).

Moreover, while the specific occupations listed under the various OAPs are meaningful, relevant, and easily understood by clients, many are unskilled or semi-skilled positions in manufacturing, i.e., glass blower, spool threader, etc., for which there is a shrinking or non-existent job market. Finally, because of the time required to administer the GATB, clients with psychiatric disabilities quite often fatigue easily and have difficulty in concentrating for the time periods required. This is a significant problem since no occupational results may be obtained when any of the subtests are incomplete.

WORK-RELATED PREFERENCES/WORK VALUES/NEEDS

Some measure of the motivational and personal values dimension of work is needed, as these factors often figure significantly in career choice. The perceived worth of a career or work goal certainly influences the motivation of the person with mental illness to overcome the fear of risk associated with any type of change, the fear of failure which might result from unsuccessful completion of a program of vocational rehabilitation, and to sustain him or herself through an often difficult, frustrating, perhaps lengthy period of training/retraining. While these personal values are less tangible and less easily and accurately measured, they are probably at least as important to examine as any "hard data" such as aptitude test scores. Preconceived notions about the worker-role, working condition preferences, perceptions of work-related stressors, the client's conception of tangible and intangible reinforcers, and his or her prioritization of these are important and may be quite different from what the typical, white, middle-class, college-educated counselor values, perhaps assumes everyone values, at least hopes that his or her clients' value; or worse, thinks that his or her clients should value.

The Career Orientation Placement and Evaluation Survey (COPES) (Knapp & Knapp, 1978), was designed to assist individuals in their career development and choices through increased self-awareness by measuring those personal values which fall under a vocational domain, the perceived importance of the work one does. The COPES consists of 160 two-choice, paired comparison items, 16 for each of the 8 value scales, which can be self-administered in from 30 to 50 minutes and is hand-scorable. Examinees are instructed that the statements represent "values which people consider to be important in their work and the activities they do," and are asked to choose the statement which best com[illegible]s the sentence "I value activities or jobs in which (I)....... ." The 8 value scales, based on a system of polarities, are:

Investigative vs. Accepting
Practical vs. Carefree
Independence vs. Conformity
Leadership vs. Supportive
Orderliness vs. Non-Compulsive
Recognition vs. Privacy
Aesthetic vs. Realistic
Social vs. Self-Concern

According to the manual, scores are interpreted in terms of a profile which compares the individual's scores with those from the normative sample, given in percentiles. Despite the dearth of validity and reliability informative available on the COPES, it is very useful as a counseling tool, since it provides a basis for more in-depth discussion of such important factors as: sources of motivation for pursuing vocational goals, the kinds of work roles and environments in which the individual would feel most comfortable and the nature of the tasks, amount of responsibility, and the kind of interpersonal interactions which the client would enjoy or at the very least be able to tolerate.

The COPES provides an initial basis and quick overview of the kinds of issues which will assume greater significance later in the vocational rehabilitation process, particularly at the time of job placement. For example, with one client, the differences between being a janitor on the night shift for a cleaning company and performing the same kinds of duties on the daylight shift for a hospital made all the difference in his success in the workplace.

It is important to note that with clients with psychiatric disabilities, the counselor cannot interpret the COPES strictly according to the manual. That is, a very high score on the Independence scale should not be followed with plans to avoid all jobs which require conformity to social conventions or adherence to rules and regulations. Rather, such a finding may be useful in exploring what is behind the client's strong desire to be free from or rebel against social conventions or authorities. A discussion of the fact that in reality there are very few occupations which permit such "total freedom" could lead to a productive dialogue concerning some adjustments the client might have to make. How to deal with this issue in a constructive manner on the job could affect his or her ability to get through a training program or to maintain employment. Moreover, many adolescents will indicate a strong preference for being the leader, "the boss", without any awareness of the stress of the increased responsibilities for autonomous functioning, decision-making, and good judgment. The COPES hen is useful both as a general indicator and a jumping off point, with rega the client's awareness of him/herself and what he/she hopes to attain through working. It serves to make the client more aware of the process and complexities involved in making good career choices and helps to modify the sometimes narrow, simplistic view of career decision-making and planning of a career-immature individual.

Edwards Personal Preference Schedule (EPPS) (Edwards, 1953, 1959).

The EPPS was designed as an instrument for research and counseling purposes to provide a quick and convenient measure of a number of relatively independent normal personality variables: achievement, deference, order, exhibition, autonomy, affiliation, intraception, succorance, dominance, abasement, nurturance, change, endurance, heterosexuality, and aggression. There are 225 items, each containing two short statements from which individuals select the statement which best describes themselves. It is untimed, self-administered in 40 to 55 minutes and may be hand-scored in 10 minutes. Norms are available for male and female college students and for a male and female adult population.

Despite a caution in the manual that the EPPS was designed for use with normal persons and is not appropriate for use with severely disturbed clients, we have found the instrument to be of great usefulness clinically. What needs the client is presently feeling most strongly, how these needs are being met, what role education or work might have in this need fulfillment process, etc., are issues which can provide a basis for discussion of client perceived needs while serving to red flag potential problem areas.

A word of caution to potential users of this test seem appropriate, however. It has been our experience that in light of the highly personal nature of much of the content of the EPPS, many clients regard it as highly personal and confidential and are sensitive as to what kinds of information about themselves they consider necessary for their "vocational counselor" to know about them. Some clients become very defensive and angry after having completed the EPPS, and we have had clients flatly refuse to return the completed form. In order to reduce or eliminate the possibility of an angry, defensive reaction on the part of the client, it is most helpful if the counselor carefully and thoroughly explains the nature of the instrument, the purpose for its use, how the client and counselor may benefit from the results, and that the results will be reviewed with the client.

PRELIMINARY PLANNING

To a great degree, an individual's ability to integrate into the world of work is contingent upon his or her capacity to formulate a realistic occupational goal. The vocational assessment procedures, described earlier in this chapter, can be instrumental in assisting clients with the complex process of generating a feasible career or prevocational plan. By providing a profile of characteristics which are relevant to career decision making, the assessment results facilitate future planning. They can enable a systematic exploration of occupational fields which might be particularly advantageous, fields to avoid and/or types of academic remediation which might be beneficial. The value of a vocational assessment largely rests upon the counselor's understanding of how to utilize the results in a manner which is most likely to be helpful to a client. The remaining portion of this chapter will provide an introduction to the use of vocational results in preliminary planning with clients. Preliminary planning is a term we are using to denote the process of sharing vocational assessment results with clients in order to help them develop realistic educational or vocational plans. Within this context, a realistic plan is one which is likely to be successful by virtue of being compatible with one's interests, abilities and tolerance for specific stressors. The extent to which a plan is realistic is also governed by general employment trends and whether the plan is defined by subgoals of manageable proportions.

The process of formulating a realistic educational or occupational plan is typically a gradual multifaceted learning process which requires exploration of oneself and career opportunities. For some individuals, this requires learning to achieve a compromise between aspirations and existing opportunities and a willingness or ability to modify goals if insurmountable obstacles are present. Other individuals may need to learn to recognize and accept their skills and abilities; this involves internalizing that they could reasonably consider career plans they have regarded as attractive but unattainable. The vocational assessment provides an important foundation for preliminary planning because it enables individuals to test their assumptions against reasonably objective findings.

TIMELINESS

Judicious timing is necessary if a vocational assessment is to be of benefit to a client. The vocational assessment can serve an integral, natural role in future planning if consideration is paid to an individual's readiness for these procedures. If undertaken prematurely, the assessment results can be misleading, increase an individual's defensiveness and/or undermine his or her self-esteem. An initial determination must be made regarding whether a client's symptomatology will significantly effect the quality of the information derived from the assessment. This is important because a vocational assessment serves as a sample of opinions and abilities from which point inferences and generalizations are made. Formal assessment procedures, such as testing, need to be delayed when individuals are in acute phases of psychiatric disorders. Often individuals experience the presence of symptomatology on a fairly consistent basis. Under these circumstances formal assessment procedures may be appropriate but the impact of symptoms must be recognized and the results need to be interpreted accordingly because symptomatology can introduce distortion into all aspects of the assessment process. For example, pronounced depressive symptomatology may obscure the revelation of areas of interest on career interest inventories. Conversely, manic symptomatology often results in interest profiles which are characterized by a confusing plethora of interests. Distortion in interest inventory results is less serious than the distortion symptomatology can have upon the measurement of abilities. Anxiety, distractibility and disorganization or blocking of thoughts all interfere with one's performance on measures of abilities. If these symptoms are present during testing, results may provide a picture of how the individual is performing at the present point in time but may underestimate future levels of performance.

The timing of an assessment also needs to be guided by the client's feelings regarding this type of appraisal. The optimal time for an assessment is when an individual presents with a desire to resolve questions regarding future plans by learning more about himself or herself. Vocational assessment procedures are not to be undertaken when clients are highly reluctant, although, resistance to testing can sometimes be diminished by exploring a client's apprehension. Embarrassment over skill deficits or wariness regarding the counselor's ability to view the test results in a helpful, nonjudgmental manner are concerns which may surface in this context. The counseling alliance may be strengthened as these issues are brought to light.

REALISM OF CAREER CHOICE

Assisting a client in the development of realistic occupational plans is a delicate, difficult process because vocational issues are often inextricably interwoven with the individual's view of himself or herself. For this reason, preliminary planning with a client requires more than a proficiency in testing or a solid knowledge of the world of work; it also requires well developed skills in psychotherapy. Because vocational counselors are often viewed as technicians, a client may be less inclined to raise emotionally laden issues in a vocational counseling session than in a psychotherapy session. This means the vocational counselor needs to be especially sensitive to the possibility that strong feelings may be present yet unarticulated. This degree of awareness and sensitivity is important throughout preliminary planning but is critical in the process of interpreting the results of vocational testing for use in preliminary planning.

One of the most common and painful situations occurs when a client presents with a highly valued but unrealistic career goal which clearly exceeds his or her capabilities. Quite often counselors receive referrals on individuals who successfully began ambitious careers prior to the onset of a chronic psychiatric illness. Equally frequent among referrals for psychiatric rehabilitation are individuals who have had minimal success in educational or career endeavors yet speak of strong beliefs that they could handle careers which require extensive preparation. What these individual have in common is that their dreams of who they might become provide a measure of comfort when faced with the difficulties of everyday life.

Whereas it is important not to encourage a client to engage in an overly deman[illegible] career endeavor, it is equally important not to precipitously destroy sustaining fantasies because these fantasies serve protective functions. The counselor needs to refrain from striving for realism "at any cost" and simultaneously avoid colluding with the client in hiding from reality. A gradual approach, in which alternatives to a cherished goal are generated and considered along side of it is useful. Often, entry level positions or limited training programs related to the career of interest can be recommended without removing the possibility of further career advancement in the future. For example, an individual who wants to become a registered nurse but who will not recognize the chances for success in this field are very slim could begin by training to be a home health care aide. Our experience has been that it is essential never to abruptly discourage a career plan and that it is far easier for an individual to relinquish a valued but unrealistic goal if viable alternatives are presented.

Frequently, discussion of the values and influences which have led an individual to have very strong feelings about a particular career can help free him or her from the consuming pursuit of an unrealistic goal. Sometimes exploration reveals that a client is aspiring to an untenable career plan because of factors in his or her relationships with family members. Excessive competition with siblings may be an important issue. In other situations, the individual may be trying to meet the expectations of a parent who had difficulty accepting his son or daughter's disorder. If these issues are productively addressed, the client may achieve a greater freedom from the constraints of the past and be able to formulate a realistic career plan which permits an opportunity for success.

The following clinical example is provided to clarify the necessity of exploring personal issues which obstruct one's ability to relinquish a career goal which is clearly unfeasible.

Carol, at 42 years of age, had been pursuing the goal of becoming a medical technologist for over seven years in order to eventually work in genetic research. This endeavor required significant self-sacrifice and consumed a great deal of her daily efforts. At the time of referral for vocational assessment, she had nearly depleted all available funds for continued education. Nonetheless, she had a considerable number of academic requirements yet to complete. A review of her grade transcript revealed that she had performed well in many classes but had been consistently unable to pass courses in the areas of science and math, subjects which are integral to her chosen academic major. Whenever possible, she delayed taking these courses or opted to drop out of them. Her performance on the abilities portion of the vocational assessment revealed deficits in numerical abilities and verbal reasoning, and her composite profile suggested that she did not have the capabilities to meet the demands of her chosen profession.

Nonetheless, Carol tenaciously held to her goal. Not until a discussion of her personal values was undertaken did it become apparent that her pursuit of th goal was motivated by unresolved feelings about having previously given bi to a child with a birth defect. This clarified the reason for her difficulty in accepting that her career goal was not realistic. She eventually decided to explore her feelings about the birth of her child in individual therapy prior to continuing with career counseling.

At this point, we have stressed the importance of assisting clients to realistically understand vocational alternatives. Realism, on the part of the clinician, is equally important and often difficult to consistently maintain. Problems in realism on the part of the clinician can stem from more than one source. In order for a counselor to be able to provide realistic career guidance, there must be an understanding both of the value and limitations of information derived from the assessment.

Most vocational batteries suggest a list of occupations which are correlated with an individual's interest and abilities profile. Whereas these lists often provide valuable suggestions, they can also be misleading for several reasons. First, some of the occupations listed rarely exist in the job market. A review of occupations listed on well established vocational assessment batteries reveals such occupations as archivist, blacksmith, merchant marine, shellfish grower and reptile farmer. Others appear on the surface to be more reasonable occupations but may, in reality, present very limited opportunities due to either local or nation-wide changes in specific industries and fields. Occupations which once prospered may no longer provide economic opportunities for new individuals entering the field. Therefore the clinician needs to be well informed of employment trends when making specific occupational recommendations on the basis of the assessment results alone. Sources such as the Occupational Outlook Handbook published quarterly by the Federal Government can help the clinician develop a more realistic understanding of the economic opportunities available in specific fields. Local newspapers and publications are also available in this regard.

The career alternatives suggested by the individual's career interest and abilities profiles only provide a framework for exploring the appropriateness of a range of potential careers. The degree to which an occupation is congruent with an individual's measured interests and abilities is a very important consideration in career decision-making, but it is not the only factor which needs to be considered. It is important to remember that other attributes related to success in specific occupations are not accounted for in this process.

Another threat to realism, on the part of the clinician, can occur if test results are interpreted in a literal or mechanistic manner. Just as clients often believe the answers to problems of career planing lie solely in test results, counselors may hold similar misconceptions. The test results are to be understood in the context of a more general appraisal of an individual's overall functioning. The maxim which reminds us to see both the forest and the trees applies to the use of test results. It is important to carefully examine the test results themselves without losing sight of the individual's life circumstances and general adjustment. Samler (1964) emphasized this point, "It is misleading to identify high mental ability and not to find out whether it is available for use, what needs energize the individual, what defenses may block his productivity - or may as a kind of secondary gain, reinforce it" (p. 413).

Recommendations regarding potential careers must be formulated with consideration to the individual's social skill repertoire, tolerance for specific stressors, psychological health and capacity to sustain goal directed behavior. Appraisal of these considerations requires clinical judgment because these determinations must be made in a subjective manner. Consequently, they are frequently affected by the clinician's feelings about specific individuals or psychiatric clients in general. In order to provide realistic career guidance, counselors need to be aware of factors which pose threats to their capacity to accurately appraise a client's functioning in domains which very much affect occupational potential but are not measurable by standard procedures. Counselors need to be attuned to inner urges to rescue or overprotect clients. Attempts to rescue a client often result in overestimating his or her capabilities; this tendency may be set in motion by either strong attraction or identification with a particular client. Underestimation of a client's potential for work may be a part of general "paternalistic" attitudes towards psychiatric clients or may be a response to an individual client who tends to elicit this response from others in order to control interactions.

Employability

It has been estimated that 60-80% of terminations by employers stem from difficulties handling nontechnical aspects of employment (Couchman, 1974). This indicates that interest, aptitude and specific job related skills are necessary but not sufficient preconditions for success in any particular job. Of equal, if not greater importance, are general and specific employability factors. General employability factors pertain to those capabilities and attitudes that are required in most work settings. They include the ability to comply with social norms governing the role of a worker and the presence of coping mechanisms and skills which are strong enough that the pressures of employment are not likely to result in deterioration. Specific employability factors pertain to aspects of an individual's attitudes, psychological functioning, and social skill--fullness which has a bearing upon his or her ability to adapt to a range of employment situations. Whereas an individual may demonstrate general employability, there may be indicators that his or her characteristics may preclude employment in specific settings. For example, a client may function well when working in rather socially isolated settings but be unable to handle the social complexities which surface in settings where there are numerous employees. While these factors must be considered carefully in preliminary planning, they generally are not accessible through formal testing.

Neff (1980) underscored the importance and difficulty of assessing an individual's ability to handle the complex social demands which are integral to work roles: "It is not too much to say that the ability to work is as much a social process, as it is cognitive or motor. The difficulty is that our capability for measuring cognitive or motor skills is far better developed than our ability to assess the subtle and delicate social adjustments which are at least as important" (p. 23)

As noted previously, the vocational assessment includes detailed interviews which focus upon an overview of an individual's attitudes towards work and an overview of his or her educational and employment history. A great deal of information which enables the evaluation of specific and general employability factors can surface in this manner. For example, a thorough vocational history will include questions which clarify the types of situations the individual needed to face on each previous job. Aspects which were gratifying or problematic are identified. Particular attention should be paid to the degree of social contact each position required and the client's ability to meet these demands. Discussion of the reasons for leaving each particular job frequently clarifies whether there is a history of problems interacting with supervisors or co-workers. Patterns pertaining to an individual's ability to cope with work in general or specific types of work can emerge both through an overview of the client's educational and vocational history and a detailed exploration of aspects of this history.

Quite frequently, the information obtained through this type of inquiry, combined with the results of formal assessment procedures and observations of the client's interactions in the sessions, provides a foundation which is solid enough to permit differential predictions regarding the client's occupational potential. However, at times, the counselor and client may be faced with important questions regarding the appropriateness of future plans which cannot be clarified through the previously described approaches. A vocational evaluation undertaken through the use of work samples, simulated work environments, volunteer or supported employment experiences may then be indicated. These types of procedures are rarely undertaken in most mental health settings and typically occur in vocational rehabilitation facilities or on-site. The use of work samples and simulated work environments as major approaches to vocational evaluation developed from the premise that "the most accurate way to assess work behavior is to actually observe individuals while they work" (Neff, 1966).

Work Samples

A work sample is "a well-defined work activity involving tasks, materials, and tools which are identical or similar to those in an actual job or cluster of jobs"

(Task Force #2, 1975, p. 55). Vocational rehabilitation programs which utilize a work sample approach to assessment generally administer a series of work samples to a client; this individual's performance on these measures is compared to a norm group which is typically comprised of individuals employed in corresponding occupations. The extended nature of this type of approach to vocational evaluation provides an opportunity to assess concrete skills and an individual's characteristic approach to work tasks.

In contrast to the use of paper and pencil assessment measures and interview formats, work samples permit the actual observation of clients as they attempt to complete tasks related to a range of jobs. Work samples are generally regarded as a positive alternative to psychometric measures because of their comparatively higher face validity, construct validity and predictive validity with regard to work performance (Pruitt, 1977). They have been viewed as particularly useful for clients with limited verbal skills or histories of educational deficiencies.

Despite the widespread use of work samples and their obvious merits, the quality of information derived through this assessment approach varies greatly and is contingent upon the skills of the vocational evaluator. In order to provide meaningful information which clarifies a client's personal strengths and limitations as related to a range of vocational activities, the vocational evaluation must be carefully planned and implemented with consideration to the client's perception of the experience of being evaluated. A systematic plan for evaluation needs to be established with the client's active involvement prior to administering work samples. The choice of work samples needs to be guided by the client's interests and the types of questions about his or her capabilities which led to the referral for a vocational evaluation. Unless the client has an understanding of the rationale behind the tasks to be performed, the evaluation will be experienced as meaningless or intrusive. This all too frequently can lead to half-hearted performance on the part of the individual being evaluated and/or judgments of the client as generally "unmotivated." This set of conditions may lead to the formulation of inaccurate conclusions regarding the client's potential for specific types of work or work in general. Although the face validity of work samples is greater than that of many psychometric measures used in vocational assessment, our experience has been that many clients fail to understand why they are being asked to complete specific tasks. The issue of work sample evaluations with individuals who are chronically mentally ill, particularly those who carry a diagnosis of schizophrenia, is highly illustrative of this very situation. The following case discussion highlights the complexities involved when individuals who are psychiatrically disabled are placed in traditional vocational evaluation settings which rely on work sample techniques as part of the vocational assessment process.

John is a thirty-year-old male who was diagnosed as suffering from an acute schizophrenic reaction four years previously. Until that time he had been employed as a security systems installer and had acquired training a number of years earlier at a local technical training program. While his social adjustment prior to his breakdown was marginal, he had been able to work successfully. John was placed on a rather potent psychotropic medication and continued to experience a number of side effects including serious motor involvement which he experienced as uncontrollable arm movements and motor agitation resembling a primary motor disorder. After remaining in his parent's home with no outside activity over the four year period, John was referred for vocational and psychological services. At the time of referral, John was motivated to return to the work place, preferably in his old line of work.

After an extensive neurological and psychological evaluation, John was referred to a local vocational center for evaluation. The evaluation was set up as a two-day per week experience as there was real concern regarding John's current abilities to deal with the stress of a highly structured environment, since he had been essentially socially and personally isolated, except for the local bars, for the preceding four years. John was placed in a work sample evaluation involving the assembly of electric lamps, as the vocational center judged this experience to closely resemble the electrical wiring and circuitry work which John had done previously. Within one month John withdrew himself from the program stating that he wanted to do security wiring work and that he was getting nothing out of lamp assembly. He then proceeded to send out resumes to various security system businesses with no success. At the same time, John's one month evaluation came from the vocational evaluation center. The report described his work skills in great detail and, from a vocational evaluation standpoint, the report was informative, explicit and well detailed. However, mention was made of John's lack of attendance on a number of occasions, and while phone contact was made with him to "remind him of the importance of attending on a regularly scheduled basis," no one at the workshop had bothered to talk with John about his experience there and thus were totally unaware of his negative reaction to the experience and his inability to see a relationship between work sample tasks and his occupation of choice. The report concluded with a recommendation that John continue in the evaluation program "for the purposes of assessing his emotional stability in the work setting and determining his vocational potential." The real issue, John's concrete thinking and inability to make connections between the here and now and his future aspirations, was never recognized.

Situational Assessment

Evaluation in simulated work settings, also known as situational assessment, refers to the process of appraising an individual's capabilities in a setting which is a realistic approximation of an actual work environment. Although the use of work samples provides an opportunity to observe clients as they work, situational assessments provide a richer source of information on the individual's work personality. The concept of work personality has been defined by Gellman (1967) as "...the characteristic pattern of work activity displayed by a person in a work situation. The work personality incorporates work attitudes, behavioral work patterns, value systems, incentives and abilities. It is the behavioral configuration regarded as necessary to function effectively in a work setting. It is a constellation distinguishing work roles from other societal roles" (p.283).

Situational assessments help answer questions pertaining to general and specific employability factors by providing information which may not have been accessible through other assessment procedures. For example, the question of whether a particular individual is able to hold gainful employment is one which is better suited to a situational assessment rather than sole reliance on interviews and psychometric testing. Extended and repeated observations of an individual in a realistic work setting enable the development of a more comprehensive understanding of an individual's work related strengths and deficiencies. A client's ability to sustain attention to tasks and engage in prolonged focused activity can be assessed. Response and need for supervision can be explored along with the individual's ability to handle the pressures which inevitably accompany entering a novel work situation. The client's ability to evaluate the quality of his or her work is frequently assessed. An individual's ability and/or willingness to comply with social norms regarding proper work attire, grooming, and prompt consistent attendance can also be addressed through this type of evaluation. Furthermore, situational assessments can provide an understanding of whether a client is able to interact with supervisors and co-workers in an adaptive manner. Questions pertaining to the client's ability to demonstrate adequate social judgment, independent problem solving, self-direction and self-control in a setting can frequently be answered.

The following case illustration is provided to illustrate how assessment procedures can be integrated into career counseling in order to facilitate systematic career decision making. A comprehensive description of the individual's scores on all assessment measures is not presented; rather, the salient factors which facilitate career decision making will be highlighted.

At the time of referral for career counseling, Edith was 37 years old and contemplating a career change. She had been diagnosed with schizophrenia, paranoid type and had a history of psychiatric treatment which dated back to her mid-twenties. Edith had been able to maintain employment as a nurse until age 33 at which time her difficulties functioning in the role of a nurse reached insurmountable proportions. Her hypersensitivity to criticism and strong dependency needs led to frequent intense feelings of rejection by other hospital staff.

Her tendency towards grandiosity combined with deficits in social judgment resulted in the alienation of supervisors and co-workers. At times she felt far more capable than the doctors and her supervisor and on these occasions she would accuse them of providing improper treatment. At other times she was troubled by feelings that treatment responsibilities were overwhelming and exceeded her capabilities. Following her fifth psychiatric hospitalization she decided to leave the nursing profession. Edith initially expressed interest in the fields of computer programming, interior design and accounting.

Following several interviews which focused on gaining an understanding of her educational and vocational history, current social functioning and thoughts regarding future career plans, a career interest inventory was administered. Elevated interest scores corresponded to the career clusters which subsumed clerical, artistic, professional business and health care occupations. Edith's career interest scores were used to expand the range of careers under consideration. Although her verbally expressed interests had not included clerical occupations, when her interest inventory scores were reviewed she noted that many of the occupations classified under the clerical career cluster seemed appealing to her. Her responses on a work values inventory underscored the value she placed on working in a setting which provides a high degree of structure, supervision and clearly stated rules and regulations. A strong preference for supportive rather than leadership roles was also evident through the results. Appearing superficially as a contrast to the aggressiveness she demonstrated in nursing, she accounted for this discrepancy by indicating that despite periodic grandiosity she basically felt "safer" when working under a higher degree of structure and supervision.

The discussion which emanated from a review of her profile on the work values inventory was instrumental in her being able to clarify the type of work environment which would be least stressful to her, a major consideration in her career planning due to the difficulties she had experienced in coping with work related pressures. Her major career choices were discussed with respect to the types of work environments and pressures she could expect to encounter.

Edith's performance on a vocational abilities battery revealed definite strengths in the areas of word knowledge, language usage and perceptual speed and accuracy. Her numerical abilities were slightly below average as was her score on a measure of inductive and deductive logic. A review of these test scores helped her narrow her career considerations. She eventually ruled out the field of accounting due to the level of her mathematical skills and became more interested in fields which would enable her to utilize her well developed language skills and strong attention to detail.

[illegible] period of exploration through the use of career resource information ens[illegible] and occupations of interest were evaluated with respect to her abilities, work conditions and employment trends. She ultimately was able to identify a specific career field, medical records technician, which appeared to be most compatible with the information she had gained about her interests, needs and capabilities. This was viewed as a particularly advantageous choice because it combined her interests in medicine and clerical work, enabled her to use her most well developed abilities, and did not require her to exercise a great deal of leadership and social judgment. At the end of several months of career counseling, Edith entered an associate degree program in order to prepare her for employment as a medical records technician.

Throughout this chapter, the reader has been reminded that only tentative conclusions can be drawn on the basis of the information derived through various assessment procedures. This is because clinicians working with vocational evaluation procedures are faced with an extremely difficult task - that of predicting how an individual will be able to meet the demands of a work role at a future point in time. Problems predicting human behavior are well known in psychiatry. Given the fluctuating nature of chronic and/or severe psychiatric disorders, the widely varying demands of individual jobs and work environments, and the complexity of human nature, a great deal of inference and clinical judgement is involved and the potential for error must be recognized. While appraising the individual's capabilities, one must be mindful of the fact that situational variables may be impinging upon the validity of assessment results. Among these variables are the client's feelings about the assessment process and his or her reactions to the professionals encountered in the evaluation settings. Changes in medication, personal concerns and the skill of evaluators also have the potential to impact significantly upon the results of an assessment. This is not to say that vocational assessment procedures cannot provide valuable information which can contribute to realistic vocational planning. Rather, it is intended as a caution that the conclusions formed in a vocational assessment need to be understood and discussed with clients as provisional in nature. When undertaken carefully, the results of a vocational assessment can provide a reasonably accurate statement of the individual's interest, work personality, strengths and limitations at the present point in time and provide a basis for limited predictions of future vocational potential.

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The Clinical Use of the Career Ability Placement Survey vs. the GATB with Persons Having Psychiatric Disabilities

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The purpose of this study was to investigate the clinical utility of the Career Ability Placement Survey (CAPS) as a tool in the vocational assessment of persons having a psychiatric disability. The CAPS and the General Aptitude Test Battery (GATB) were administered to a sample of 91 individuals with varied DSM-III psychiatric diagnoses. Vocational aptitude scores yielded by the CAPS were compared to those obtained on conceptually similar tests of the GATB. Correlation coefficients were used to evaluate the relationship between the two measures. In addition, the independence or degree of differentiation of the tests within each battery was assessed and confirmed by factor analysis. High positive correlations were obtained for conceptually similar tests. While test intercorrelations within each battery exhibited an acceptable level of independence, greater independence was found within the CAPS structure. Factor analysis confirmed that the CAPS contained a three-factor solution, whereas the GATB showed a two-factor structure. These results, coupled with the fact that the CAPS is more efficiently administered, indicated that the CAPS might have clinical advantages when used with this population.

The Rehabilitation Act of 1973 (PL93-112) and its subsequent amendments (Rehabilitation Acts Amendment, 1986) gives priority to the provision of vocational rehabilitation services to persons having severe disabilities including those with psychiatric disorders as preparation for their entrance into the work force. Among the vocational rehabilitation services authorized in the Act is that of vocational assessment. However, in contrast to the successful use of psychometric measures to assess the vocational capacity and aptitudes of persons with physical disabilities, the use of vocational assessment procedures with persons who have psychiatric disabilities has been problematic.

Anthony and Jansen (1984) cited six studies which evaluated the predictive validity of traditional psychological and vocational tests with persons who were psychiatrically disabled. These tests included the Wechsler Adult Intelligence Scale (WAIS), the General Aptitude Test Battery (GATB), and other routinely used psychological test batteries. Results of these studies indicated that intelligence, aptitude, and personality tests were poor predictors of future work performance for this population. However, it must be pointed out that the predictive validity of vocational aptitude tests, in particular, relate to potential success in particular occupations. Vocational aptitude tests were never intended to predict global concepts such as future work performance. Moreover, hospital recidivism rates and loss of employment resulting from the exacerbation of psychiatric disorders were major contributing factors to subsequent vocational outcomes in all of these studies.

With these cautions in mind, vocational counselors can view vocational aptitude testing as an initial assessment tool in the rehabilitation counseling process with persons having psychiatric disabilities. Aptitude tests traditionally have provided a method of assessing areas of strengths and deficits in individuals who might be uncertain of their own academic or vocational potential. Aptitude test results are of value when working with individuals who may have either an inflated or self-depreciating view of their capabilities. They are also useful with those persons who have little substantive or accurate knowledge of the world of work. It is often the case that persons with psychiatric disabilities, by virtue of the age of onset of their illness and its severe impact on major life events such as the choice of a career or retention of employment once in the market place, have particular knowledge deficits for which aptitude testing has been shown to be highly appropriate and useful.

The efficacy of aptitude testing with respect to self-knowledge and vocational planning with clients having schizophrenic disorders was demonstrated by Bidwell (1969). Her results showed that clients chose vocational goals congruent with their own understanding of their aptitudes and interests but were not generally aware of their actual aptitudes and interests. Anthony, Howell, and Danley (1984) underscored the special vocational counseling and job readiness needs of persons having psychiatric disabilities stating, "More time is needed to go through the process because of the clients' vocational immaturity. More energy is needed to form a collaborative relationship with clients who are used to having things done to and for them rather than with them" (p. 233). They suggested a deliberate refocusing of the helping process on those specific skills and supports needed by the clients themselves.

Miller and Benjamin (1975), advocating that the unique needs of special populations should act as an impetus to develop vocational rehabilitation programs tailored to the individuals actually served, called for an expansion of strategies used in career guidance programs. To meet the vocational rehabilitation needs of these special populations including persons with psychiatric disabilities, however, vocational counselors have been forced to use vocational assessment strategies currently at their disposal. Often the psychometric properties of these measures in terms of their development and standardization have not allowed for accurate assessment of persons with psychiatric disabilities. Floyd (1964) stressed that as vocational counselors formulate plans to meet the needs of this population, they tend to use instruments with which they are most familiar and which have, to some extent, known empirical validity with a nondisabled population. This a priori decision is still necessitated today due to the lack of validity studies on vocational aptitude measures used with clients who have psychiatric disabilities.

The General Aptitude Test Battery (GATB) (U.S. Department of Labor, 1947-1979) is a multiple aptitude battery developed by the United States Employment Service for use in occupational counseling programs. The battery consists of 12 tests measuring the following 9 aptitudes: Intelligence, Verbal Aptitude, Numerical Aptitude, Spatial Aptitude, Form Perception, Clerical Perception, Motor Coordination, Finger Dexterity, and Manual Dexterity. Eight of the tests are paper and pencil tests and four are performance tests which require special equipment for their administration. A trained technician administers the battery; it is timed and requires 2 1/2 hours to complete. The battery yields Occupational Aptitude Patterns (OAPs), combinations of three GATB aptitudes and associated cutting scores for groups of occupations having similar aptitude requirements. An individual's degree of aptitude for various occupations associated with the 66 OAPs is indicated with a letter grade of High, Medium, or Low as outlined in the test manual (USDL, 1979).

The GATB is one of the most widely used vocational aptitude measures. The battery has been employed with a variety of special populations and disability groups, such as juveniles at a diagnostic center, persons having mental retardation or learning problems, high school drop-outs, special education students, and persons with hearing problems (Mueller, 1964; Huddy, 1968; Droege, 1968; Helwig, 1972; Kujoth, 1973; Rhoton, 1975; Botterbusch & Droege, 1972; Sanderson, 1974; Droege & Mugaas, 1976). As testimony to its continued and highly extensive use in the job referral process, in 1987, the U.S. Department of Labor directed the National Academy of Science to review the GATB in terms of Validity Generalization, the basis for referral to all 12,000 jobs in the **Dictionary of Occupational Titles** with particular concern around persons with disabilities (Washington Update, October 22, 1987).

Little work, however, has been done in evaluating the usefulness of the GATB with persons having psychiatric disabilities. In one of the few studies reported, Ciardiello (1981) evaluated the GATB as a predictive measure of job placement success for 66 clients with schizophrenia in a workshop setting. In general, GATB scores for this sample were significantly ($p < .01$) lower than scores for a general population, with largest differences on the Assemble and Disassemble parts of the Finger Dexterity Scale. In a discriminate function analysis the Assemble test of the GATB was found to be the best single predictor of job placement ($p < .01$). This finding suggested that those clients with higher scores on this subtest were more likely to successfully complete sheltered workshop programs where work experiences required finger dexterity and subsequently to be placed in jobs. The study concluded that a standardized vocational instrument such as the GATB offered the possibility of making practical predictions regarding job placement for clients with schizophrenia.

The use of the GATB in a clinical setting with individuals who have a psychiatric disability raises several issues of significant practical and logistical concern, namely: (1) the 2 1/2 hour administration time; (2) the training requirements for administration; (3) the specialized equipment and space needs; (4) the time-consuming scoring procedures in which there is a high probability for error rate; and, (5) the fact that the test is geared to group rather than individual administration. From a therapeutic perspective, group testing of persons having psychiatric disabilities may be highly threatening and anxiety provoking, especially to inpatients. Moreover, part of the process of psychiatric rehabilitation is the establishment of rapport with an individual, a process best accomplished on a one-to-one basis. Finally, the rigorous testing procedures required are not conducive to "best effort" participation on the part of this clientele due to factors such as fatigue, distractibility, previous failure experiences, and test anxiety.

The Career Ability Placement Survey (CAPS) (Knapp & Knapp, 1984) is a battery of eight 5-minute paper and pencil tests which includes measures of Mechanical Reasoning, Spatial Relations, Verbal Reasoning, Numerical Ability, Language Usage, Word Knowledge, Perceptual Speed and Accuracy, and Manual Speed and Dexterity. The battery was first published in 1981 as a standardized measure of abilities related to occupations and careers. It is designed to be used in conjunction with the California Occupational Preference System Interest Inventory (COPS) career clusters, a group of 14 skilled and professional job classifications (Knapp & Knapp, 1984).

The CAPS was normed on nearly 7,000 students in grades through 12 across five geographical regions of the county as well as on a sample of 1700 community college students (Knapp & Knapp, 1984). The test manual reports correlations of the CAPS with the GATB, the Employee Aptitude Survey (EAS), the Differential Aptitude Test (DAT), the Iowa Tests of Educational Development (ITED), the Metropolitan Achievement Tests (MAT), and school marks using various 8th, 9th, and 10th grade samples. A predictive validity study involving over 2,000 high school graduates who had been administered the CAPS while in their high school years is ongoing. Preliminary results indicate a 97% hit rate. A hit was defined as the correspondence of the college goal or present job to a CAPS career area designated by the previously obtained CAPS scores.

The CAPS has not been extensively used or empirically studied with special populations, however, it appears to present some advantages for use with persons having psychiatric disabilities. Specifically, (1) the total testing time for counselors working with these persons is less than one hour; (2) the series of eight tests is administered in the office setting, one-on-one with the counselor; (3) no special apparatus or space is required; and, (4) no special training is required for administration. Furthermore, the test can be scored by the client, another method of investing him or her in the rehabilitation process. This opportunity for immediate feedback increases the "face validity" of the instrument with individual clients because of the direct link which can be made between the ability scores and the fourteen career clusters identified.

For these reasons, it seemed desirable to determine whether the tests could be viewed as comparable in terms of their results with a population of individuals having a psychiatric disability. If so, the use of the CAPS in a clinical setting would be more soundly supported. In this study, vocational aptitude scores yielded by the CAPS were examined and compared to those obtained from the GATB, a test which has been researched in a continuing program of developmental and occupational validation since its publication in 1947.

The following issues were addressed:

1. What is the relationship between the GATB individual aptitude scores and the CAPS ability scores? It might be expected that certain CAPS abilities would be related to selected GATB aptitudes. For example, the CAPS Manual identifies the CAPS Spatial Relations, Word Knowledge, Numerical Ability, and Perceptual Speed and Accuracy tests as conceptually similar to the GATB measures of Spatial Aptitude, Verbal Aptitude, Numerical Aptitude, and Clerical Perception respectively. Therefore, a strong positive relationship between these scores would be anticipated (Knapp & Knapp, 1984).
2. Do the tests within the GATB battery and the tests within the CAPS battery remain sufficiently independent or differentiated to yield separate measures of aptitudes or abilities when a sample of persons with psychiatric disabilities is tested?
3. How do the factor solutions that account for the variances of each battery compare?

Method

Subjects

Ninety-one individuals (24 outpatients and 67 inpatients), selected at random, who were seen as either inpatients or outpatients at a large, urban, university-based psychiatric facility were involved in this study. Ages ranged from 14 to 50 years (Mean = 23.9, SD = 9.48). Eighty-two subjects were White, 8 were Black, and 1 represented another minority. Education obtained averaged 11.2 years with a range of 7 to 18 years (Median = 11.0). The mean Full Scale IQ as measured by the Wechsler Adult Intelligence Scale - Revised (WAIS-R) or the Wechsler Intelligence Scale for Children - Revised (WISC-R) was 94.11, with a range of 68.00 to 128.00 (SD = 12.79). A mean Verbal IQ of 94.40 (SD = 12.49) compared to a mean Performance IQ of 94.53 (SD = 12.87).

The subjects had been previously diagnosed using the American Psychiatric Association's **Diagnostic and Statistical Manual of Mental Disorders** (DSM-III), Third Edition, 1980. 42.9% (n = 39) of the group had more than one DSM-III diagnosis. Overall, 30% of the diagnoses were disorders usually first evident in childhood or adolescence; 28.2% fell in the category of an affective disorder; 14.6% were personality disorder, 13.6% were schizophrenic disorders, and 13.6% were anxiety or adjustment disorders.

Procedure

Between 1982 and 1986 randomly selected inpatients and outpatients referred to the Department of Neuropsychological Assessment and Rehabilitation Services (Western Psychiatric Institute and Clinic, University of Pittsburgh) for vocational assessment were administered both the GATB and the CAPS. Pearson product moment correlations were calculated between the GATB aptitude scores and the CAPS ability scores in order to assess whether the relationship of the conceptually similar tests identified by Knapp & Knapp (1984) was still apparent when the tests were used specifically with a psychiatric population. To further evaluate the results of these tests in

Table 1
Correlations of CAPS Ability Scores and GATB Aptitude Scores

CAPS Abilities	GATB Aptitudes G	V	N	S	P	Q	K	F	M
Mechanical Reasoning	.33			.46	.21*			.22*	
Spatial Relations	.50	.23	.32	.60[a]	.34	.21*		.34	.27
Verbal Reasoning	.60	.45	.43	.48	.41	.36	.26	.43	.25
Numerical Ability	.60	.52	.75[a]	.28	.41	.51	.38	.32	.24*
Language Usage	.64	.76	.61	.26	.42	.56	.60	.37	.30
Word Knowledge	.70	.81[a]	.61	.33	.37	.47	.48	.35	.28
Perceptual Speed & Accuracy	.42	.44	.47	.22*	.67	.65[a]	.62	.55	.62
Manual Speed & Dexterity	.24	.19*	.23*	.22*	.41	.30	.52	.40	.54

Note. All nonsignificant correlations omitted.
[a] Conceptually similar tests.
$p < .01$, * $p < .05$

Table 2
Comparison of Correlations Between Conceptually Similar Tests

	Study Sample	Normal Population[a]
CAPS Word Knowledge/ GATB Verbal Aptitude	.81	.80
CAPS Numerical Ability/ GATB Numerical Aptitude	.75	.67
CAPS Spatial Relations/ GATB Spatial Aptitude	.60	.63
CAPS Perceptual Speed & Accuracy/ GATB Clerical Perception	.65	.70

[a] From CAPS Examiner's Manual (p. 20) by Lila Knapp and Robert Knapp, 1981, San Diego: EdITS.

comparison to those reported during test development, the independence of the abilities or aptitudes within each battery was examined. A Pearson product moment intercorrelation matrix was calculated for the 9 GATB aptitudes, the 12 GATB test scores, and also for the 8 CAPS ability scores. Principal components factor analysis was then carried out for each battery. Adequately determined factors were rotated to simple structures by the varimax procedures outlined in Gorsuch (1982).

Results

Correlation of GATB Aptitudes and CAPS Abilities

The statistically significant correlations between the GATB individual aptitude scores and the CAPS ability scores are included in Table 1. Correlations are .60 or above ($p < .01$) for tests which the CAPS' authors identify as conceptually similar. For example, CAPS Word Knowledge correlates with GATB Verbal Aptitude at .81 and CAPS Perceptual Speed and Accuracy correlates with GATB Clerical Perception at .65. Other tests with overlapping content, CAPS Word Knowledge/GATB Intelligence and CAPS Language Usage/GATB Verbal Aptitude, showed the expected high correlations while dissimilar tests showed the desirable low correlations.

Before any decision could be reached concerning the use of the CAPS as opposed to the GATB, it was necessary to determine not only whether the conceptually similar tests selected from the two batteries showed high correlations for this sample of persons with psychiatric disabilities but also whether the correlations of this sample were similar to those obtained when a normal population was compared using the same batteries. In general the correlations of the GATB aptitudes and CAPS abilities produced by this sample (See Table 2) were similar in direction and size to those reported for the normal population in the CAPS test manual (Knapp & Knapp, 1984). There appeared to be enough similarity to suggest that the relative performance on the two test batteries of clients in this sample would be comparable to the performance of normal populations when conceptually matched aptitudes were examined.

Inter-test Correlation and Factor Analysis

The performance of this sample was also evaluated by: (1) assessing the degree of independence of the individual tests of each battery; and (2) comparing the results to those provided by each test developer. The intercorrelations among the vocational aptitudes for each battery provided information regard-

Table 3
GATB Aptitude Scores: Intercorrelation Matrix

Aptitude	G	V	N	S	P	Q	K	F
G - Intelligence								
V - Verbal Aptitude	.80							
N - Numerical Aptitude	.81	.73						
S - Spatial Aptitude	.69	.36	.42					
P - Form Perception	.52	.48	.51	.43				
Q - Clerical Perception	.65	.68	.73	.34	.73			
K - Motor Coordination	.43	.49	.44	.15	.48	.51		
F - Finger Dexterity	.52	.47	.44	.40	.59	.49	.60	
M - Manual Dexterity	.35	.33	.35	.30	.53	.46	.69	.74

$p < .01$

Table 4
GATB Test Scores: Intercorrelation Matrix

Test	1	2	3	4	5	6	7	8	9	10	11	12
1-Name Comparison												
2-Computation	.71											
3-Three Dimensional Space	.34	.33										
4-Vocabulary	.67	.70	.35									
5-Tool Matching	.70	.47	.36	.43								
6-Arithmetic Reasoning	.62	.71	.46	.67	.39							
7-Form Matching	.62	.39	.40	.46	.69	.44						
8-Mark Making	.51	.42		.49	.45	.40	.44					
9-Place	.37	.28	.18	.20	.44	.20	.38	.60				
10-Turn	.46	.34	.33	.36	.41	.30	.46	.65	.62			
11-Assemble	.44	.35	.34	.42	.47	.39	.48	.54	.54	.72		
12-Disassemble	.46	.39	.38	.42	.55	.40	.54	.56	.59	.64	.64	

Note. All nonsignificant correlations omitted.
$p < .05$

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ing the differentiation of the measured aptitudes when that particular battery was used to assess this special client group.

Intercorrelations among the GATB aptitude scores are presented in Table 3. All intercorrelations were significant (p. < 01). Coefficients for this sample range from .15 (Spatial Aptitude/Motor Coordination) to .81 (Intelligence/Numerical Aptitude). Intelligence also shows high correlations with Verbal Aptitude and Spatial Aptitude, .80 and .69 respectively. The median intercorrelation is .49. Results for this sample were similar to intercorrelations of GATB aptitude scores based on a sample of 2,649 persons as reported in the GATB test manual. The coefficients reported for that sample of a normal population ranged from .16 (Spatial Aptitude/Motor Coordination) to .78 (Intelligence/Numerical Aptitude). The median intercorrelation for the group was .39 (USDL, 1970).

Table 5

CAPS Ability Scores: Intercorrelation Matrix

Ability	MR	SR	VR	NA	LU	WK	PSA
MR-Mechanical Reasoning							
SR-Spatial Relations	.48						
VR-Verbal Reasoning	.23	.48					
NA-Numerical Ability	.14	.21	.40				
LU-Language Usage		.25	.43	.56			
WK-Word Knowledge	.23	.25	.46	.49	.70		
PSA-Perceptual Speed & Accuracy			.24	.39	.43	.36	
MSD-Manual Speed & Dexterity		.20	.20	.19	.21	.20	.41

Note. All nonsignificant correlations omitted.
p < .05

The intercorrelations of the GATB aptitudes for this sample generally agreed with the results of samples from a normal population (USDL, 1970). However, since Intelligence, Verbal, and Numerical Aptitudes are composed of scores from some of the same tests, these aptitudes would be expected to show higher correlations among themselves than they do with the other aptitudes. Because these aptitudes were related in this way, they were excluded from consideration when assessing the independence of the aptitudes. After excluding the G, V, and N aptitudes, the remaining GATB aptitudes correlated at a generally higher level than did the CAPS abilities. Of the 33 coefficients considered, 13 were above .50 and only one was below .25.

Table 6

Eigenvalues, Communalities, and Percentage of Variance: Two-Factor Solution of GATB

Test	Communality	Factor	Eigenvalue	% of Variance
1- Name Comparison	.75406	1	6.16161	51.3
2 - Computation	.73356	2	1.1486	13.5
3 - Three Dimensional Space	.30673			
4 - Vocabulary	.71703			
5 - Tool Matching	.56080			
6 - Arithmetic Reasoning	.73899			
7 - Form Matching	.54357			
8 - Mark Making	.61183			
9 - Place	.70255			
10 - Turn	.74962			
11 - Assemble	.66799			
12 - Disassembl e	.68974			

To obtain a more accurate measure of the independence of each test, a correlation matrix of the GATB test scores was evaluated. The correlation matrix of the 12 GATB test scores is presented in Table 4. Values of the significant (p. < 05) correlation coefficients for this sample range from .18 (Place/Three Dimensional Space) to .72 (Assemble/Turn). The median intercorrelation was .44. Several of the tests showed a rather high correlation. For example, Name Comparison correlated with Computation at .71, Vocabulary with Computation at .70, and Vocabulary with Name Comparison at .67.

Table 5 presents the statistically significant (p.<05) intercorrelations among the CAPS abilities for the 91 subjects. Intercorrelations for this sample range from .14 (Numerical Ability/Mechanical Reasoning) to .70 (Word Knowledge/Language Usage) with a median coefficient of .305. The CAPS test manual presents intercorrelations based on samples of 422 tenth grade students and 197 community college freshman. Results from these samples show a similar range of .15 (Manual Speed and Dexterity/Spatial Relations) to .67 (Word Knowledge/Language Usage) with a median coefficient of .35 for the tenth grade students and .01 (Manual Speed and Dexterity/Mechanical Reasoning) to .63 (Word Knowledge/Language Usage) with a median coefficient of .29 (Knapp & Knapp, 1981). In general, intercorrelations for the tests in the CAPS battery for this sample are as low or somewhat lower than those reported for a normal population.

Anastasi (1982) suggests that when assessing a test battery it is important to inspect the intercorrelations within the battery because "Tests correlating highly with each other represent needless duplication" (p. 175). Generally, the CAPS intercorrelations were lower than those of the GATB. Only 2 of the 24 significant CAPS coefficients were over .50, with 12 coefficients .25 or lower. In comparison, 22 of the 65 significant GATB test score coefficients were above .50 and only 3 were lower than .25. These results suggest that the CAPS abilities are more in-

Table 7
Varimax Solution of GATB

Test	Factor 1	Factor 2
1 - Name Comparison	.788	.364
2 - Computation	.840	.166
3 - Three Dimensional Space	.508	.220
4 - Vocabulary	.823	.198
5 - Tool Matching	.542	.517
6 - Arithmetic Reasoning	.849	.133
7 - Form Matching	.535	.507
8 - Mark Making	.322	.713
9 - Place	.055	.836
10 - Turn	.200	.842
11 - Assemble	.283	.767
12 - Disassemble	.323	.765

dependent than the GATB aptitudes for this sample of clients having psychiatric disabilities.

Table 8
Eigenvalues, Communalities, and Percentage of Variance: Three-Factor Solution of CAPS

Ability	Communality	Factor	Eigenvalue	% of Variance
Mechanical Reasoning	.67396	1	3.25336	40.7
Spatial Relations	.74981	2	1.30859	16.4
Verbal Reasoning	.57555	3	1.02851	12.9
Numerical Ability	.60214			
Language Usage	.77844			
Word Knowledge	.71318			
Peceptual Speed & Accuracy	.68184			
Manual Speed & Dexterity	.81553			

Table 9
Varimax Solution of CAPS

Ability	FACTOR 1	FACTOR 2	FACTOR 3
Mechanical Reasoning	.025	.819	.048
Spatial Relations	.185	.840	.099
Verbal Reasoning	.573	.494	.054
Numerical Ability	.755	.073	.163
Language Usage	.864	.051	.173
Work Knowledge	.820	.170	.105
Perceptual Speed & Accuracy	.407	-.009	.717
Manual Speed & Dexterity	.034	.152	.889

Principal components factor analysis was carried out on each battery in order to test this hypothesis. Initial principal components analysis of the GATB data resulted in two factors with an eigenvalue greater than 1.0. This criterion is suggested by Gorsuch (1983) when dealing with less than 40 variables and when the number of factors is expected to be between v/5 and v/3. Table 6 shows the eigenvalues, communalities, and percentages of variance of the two extracted factors. The factor matrix after orthogonal rotation to simple structures using the varimax solution is presented in Table 7. The two factors necessary to account for the correlation matrix might be designated as cognitive and psychomotor.

Initial principal components analysis of the CAPS correlation matrix resulted in three factors with eigenvalues greater than 1.0. Table 8 lists the eigenvalues, communalities, and percentages of variance of the three extracted factors. The factor matrix of the CAPS after orthogonal rotation to simple structure using the varimax solution is shown in Table 9. These three factors might be labeled verbal, perceptual, and psychomotor.

The GATB correlation matrix of test scores produced a two-factor solution that accounted for 64.8% of the variance. The CAPS matrix yielded a three factor solution, accounting for 70.0% of the variance. Inspection of Table 9 reveals that only one CAPS ability, Verbal Reasoning, loaded fairly evenly on two of the three factors. The factor loading of the GATB, on the other hand, indicated that two of the tests, Form Matching and Tool Matching, loaded on both factors almost identically. These results might indicate that although the CAPS is a shorter test, it assesses three independent constructs rather than the two independent constructs of the GATB.

Discussion

The purpose of this study was to determine the clinical utility of the CAPS versus the more well established GATB with a population of individuals who were psychiatrically disabled. Superior clinical utility was viewed as being based upon client acceptance, ease of administration, reduced period of actual testing time, and the capacity of the assessment instrument to yield a differentiated aptitude structure.

Client acceptance considerations would tend to favor the CAPS because it is briefer and time constraints are less demanding. It is also designed for individual rather than group administration. Although the GATB can be administered individually, this is not usually recommended. Perhaps more significantly, however, the CAPS was found to generate a more differentiated aptitude structure than did the GATB. This conclusion was demonstrated by lower intercorrelations among the CAPS ability scores than among the GATB aptitude scores. Confirmation of this conclusion was obtained from the factor analytic results. The CAPS yielded three factors that met acceptable extraction criteria, while the GATB only yielded two factors.

Correlations between apparently corresponding tests from the two batteries were reasonably high, suggesting that the two procedures assess about the same ability domains. However, the more differentiated structure of these domains in the case of the CAPS would appear to allow for the formulation of more specific predictions concerning vocational aptitudes. We would speculate that this structural difference is related to difficulty level considerations. A test battery that is too difficult with regard to content or time constraints for a particular population is more likely to generate higher intercorrelations among its components than would be the case for a test battery having a more appropriate difficulty level.

It should be emphasized that the present study does not prove that one test procedure has better predictive validity than the other. It is still necessary to compare the accuracy of the advice given to clients on the basis of the OAPS and CAPS ratings. Furthermore, the present findings may be refined by considering subgroups of clients with different diagnoses. An examination of predictive validity and results for different diagnostic groups could enhance the clinical usefulness of both procedures. This study does point out, however, that because of its psychometric properties and practical considerations such as simple format and individual administration, the CAPS replicates the domains assessed by the GATB but may have certain advantages in the vocational counseling of clients who have psychiatric disabilities.

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Journal of Applied Rehabilitation Counseling

Can the Performance of Psychiatric Patients on the General Aptitude Test Battery be Predicted from the Career Ability Placement Survey?

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The study evaluated the accuracy with which one could estimate General Aptitude Test Battery (GATB) scores on the basis of performance on the Career Ability Placement Survey (CAPS) in a sample of 147 psychiatric patients who had received both procedures. Multiple regression analysis was used in which CAPS scales were used as independent variables and GATB scales as dependent variables. Multiple correlation coefficients (Rs) were found to be statistically significant for all twelve GATB scales. A cross-validation achieved by splitting the sample in half and performing separate multiple regression analyses for each subsample was successful, indicating that the regression coefficients were stable. Stepwise analyses indicated which CAPS scales were the most powerful predictors, of the various GATB scales. Analysis of the residual scores indicated that predictive accuracy increased as scores approached average levels. It was also noted that the CAPS predicted more accurately to the GATB paper-and-pencil tests than to the performance tests. It was concluded that the CAPS can predict GATB scores reasonably accurately, but caution should be exercised when predicting scores of individuals with extremely high or low CAPS scores, or when estimating GATB performance test scores.

Katz, Beers, Geckle and Goldstein (1989) compared the General Aptitude Test Battery (GATB) (1970) with the Career Ability Placement Survey (CAPS) (Knapp & Knapp, 1984) with the aim of determining which of the two procedures was clinically more advantageous for the vocational assessment of individuals with psychiatric disabilities. Both the GATB and the CAPS are batteries of cognitive, perceptual and motor tests commonly used to evaluate vocational aptitudes. The GATB consists of eight paper-and-pencil tests and four tests that require the use of apparatus (a board, pegs, rivets and washers). The CAPS consists of eight paper-and-pencil tests.

Utilizing correlational and factor analyses, Katz et al. reached what may be summarized as three conclusions. First, there are robust, significant correlations between conceptually similar CAPS and GATB components. Second, the CAPS yields a more differentiated factor structure in psychiatric patients than does the GATB. Finally, they concluded that in view of the above findings and the fact that the CAPS is a briefer and more efficiently administered procedure than the GATB, it may be the instrument of choice for vocational assessment o psychiatric patients.

Despite these considerations, the GATB remains the "gol standard" for vocational assessment, and is very commonly use for job referral in both the general population and a wide variet of clinical populations. A recent review of the GATB con ducted by the National Academy of Science (Hartigan & Wig dor, 1989) provided a generally favorable report with regard t its predictive validity. As a general conclusion, this documen states:

> A thorough evaluation of the General Aptitude Test Battery (GATB) leads us to conclude that the test has modest levels of validity for predicting job performance, and that these predictive validities are strong enough to produce some enhancement of worker performance for individual employers who use test information in selecting employees. (p. 281)

The massive endeavor made to form that conclusion has n yet been accomplished in the case of the CAPS. Therefor while the CAPS may have numerous advantages in terms of a propriateness for psychiatric patients, the availability of GAT scores, or GATB score equivalents, may be to the advantage those patients because of the wide application and acceptan of the GATB.

In view of these considerations, it appeared that some a vantages could be gained if the capability became available estimating GATB scores from CAPS data. The finding of hi correlations between CAPS and GATB scales reported by Ka et al. lent some hope to the possibility of achieving such a g in a psychometrically satisfactory manner. That is, multip regression equations could be generated between sets of CAPS scores as independent variables and GATB scores as the dependent measures. If such equations yielded sufficiently high multiple correlation coefficients, then predicted GATB scores could be generated from CAPS scores with acceptable accuracy levels. If this undertaking proved successful, then patients would be able to benefit from the psychometric and administrative advantages of the CAPS, while at the same time having access to an accurate set of GATB score estimates. The study reported on here was an attempt to achieve that goal in a heterogeneous sample of psychiatric patients.

METHOD

Subjects. The sample consisted of 147 patients referred for vocational assessment to the Neuropsychological Assessment and Rehabilitation Services of Western Psychiatric Institute and Clinic. The mean age was 26.47 years (SD = 10.08) with a range of 14 to 53 years. The mean educational level was 11.75 years (SD = 2.3) with a range of 7 to 18 years. There were 78 female and 69 male subjects. The Axis I or II DSM-III psychiatric diagnoses (APA, 1980) were 5 nonparanoid schizophrenics, 15 paranoid schizophrenics, 1 atypical psychosis, 29 unipolar mood disorders, 14 bipolar mood disorders, 8 schizoaffective disorders, 6 anxiety disorders, 8 dysthymic or cyclothymic disorders, 7 personality disorders, 1 adjustment disorder, 16 situational reactions, 10 substance use disorders, 14 disorders first evident in infancy, childhood or adolescence, 10 eating disorders, 1 client with mental retardation, 1 organic mental disorder, and 1 specific developmental disorder.

Procedure. All subjects included in the study received both the CAPS and the GATB, which were individually administered as parts of their vocational assessments. Results were computer scored and filed in a database for further analysis. The data analysis consisted of a series of multiple regression analyses with the eight CAPS ability scores used as independent variables and the 12 GATB subtest scores as the dependent variables. The GATB test scores were used rather than the aptitude scores since the aptitude scores are not orthogonal. That is, some of the aptitude scores are based on items included in more than one of the individual tests. A separate equation was written for each of the twelve GATB test scores.

Initially, the sample was split into two halves on an odd-even basis in order to do a cross-validation. Separate sets of regression equations were computed for the two subgroups and a determination was made as to whether or not the corresponding regression equations in each subgroup differed at a statistically significant level from each other. The statistical test used was an analysis of variance testing for equality of lines across groups. The procedure is described in Dixon (1985). Basically, a nonsignificant F-ratio indicates that the two subgroups have similar regression equations. If that is the case, it is permissible to combine the two subgroups and calculate regression equations for the total sample. Following these analyses, regression equations were recomputed using the stepwise method in order to determine which combinations of CAPS scales are the most powerful predictors of the various GATB scales. An analysis of the residual scores, or differences between actual scores and those predicted by the regression equations, was also conducted in order to detect possible differences in predictive accuracy along ranges of scores.

RESULTS

Initial Validation and Cross-Validation. As indicated, the sample was initially split in half and separate sets of regression equations were computed for each half. Then analyses of variance testing for equalities of lines across groups were performed. The multiple correlation coefficients (Rs), F-ratios and associated probabilities for each of these analyses are presented in Table 1. None of the F-ratios were statistically significant. Thus, cross-validation was successful for all twelve equations in that none of the corresponding pairs of sets of equations differed significantly from each other. We therefore combined the two subsamples and recomputed the regression equations for the total sample. These equations and their associated Rs are presented in Table 2. The Rs range from .50 to .80, with the percentages of explained variance (R^2) ranging from 25% to 64%. All of the Rs are statistically significant ($p < .001$), but actual application of the equations depends, of course, upon one's tolerance level for unexplained variance ($1 - R^2$).

Table 1.
Multiple Correlation Coefficients (Rs) and Analyses of Variance Results for Equality of Lines Across Groups

GATB Scale	Group 1 (n = 74) R	Group 2 (n = 73) R	F	p
Name Comparison	.73	.75	1.21	> .05
Computation	.80	.75	.95	> .05
3-Dimensional Space	.72	.71	.75	> .05
Vocabulary	.81	.82	.99	> .05
Tool Matching	.66	.71	1.27	> .05
Arithmetic Reasoning	.71	.78	1.56	> .05
Form Matching	.72	.61	1.19	> .05
Mark Making	.69	.78	.37	> .05
Place (Pegs)	.53	.67	.42	> .05
Turn (Pegs)	.63	.48	.96	[illegible]
Assembly (Rivets)	.58	.50	.39	[illegible]
Disassembly (Rivets)	.57	.62	.49	> .05

Stepwise Analyses. These analyses were conducted in order to determine the most powerful CAPS predictor sets for each of the GATB subtests. Stepwise analysis allows for identification of the most powerful predictor variable, and also computes the cumulative increments in explained variance provided by the addition of predictors. Table 3 contains the CAPS scale entered into the regression equations by order of entry for each of the GATB tests as well as the increment in explained variance contributed by each scale entered. Entry of scales stopped when the probability value of the F-to-enter exceeded .05. This value is the default assigned by the SPSS^X REGRES

Table 2.
Multiple Correlation Coefficients (Rs) and Multiple Regression Equations Using the Eight CAPS Scales as Independent Variables and the GATB Scales as Dependent Variables

GATB Scale	R	Regression Equations
Name Comparison	.72	17.16-.30(MR) - .31 (SR) - .67 (VR) - 1.25 (NA) - 1.63 (LU) - .31(WK) - 3.56 (PS) - .49 (MS)
Computation	.75	7.32 - .32 (MR) - .40(SR) - .41 (VR) - 1.57 (NA) - .22(LU) - .01(WK) - .31(PS) - .03(MS)
3-Dimensional Space	.70	2.53 - .77(MR) - .97 (SR) - .93 (VR) - .39 (NA) - .34(LU) - .26(WK) - .29(PS) - .10(MS)
Vocabulary	.50	4.13-.11(MR) -.01(SR) - .34 (VR) - .43 (NA) - 1.29(LU) - 1.23(WK) - .25(PS) - .20(MS)
Tool Matching	.55	14.76-.10 (MR) + .36 (SR) - .56 (VR) - .29 (NA) - .06(LU) + .22(WK) - 1.75(PS)-.02(MS)
Arithmetic Reasoning	.72	1.98 - .09 (MR) + .22 (SR) - .14 (VR) - .50(NA) - .07(LU) + .33(WK) + .01(PS) - .10(MS)
Form Matching	.54	10.01 - .14 (MR) + .65(SR) - .36(VR) - .12 (NA) - .10(LU) - .04(WK) - 1.50(PS) - .23(MS)
Mark Making	.73	43.73-2.80 (MR) -.07 (SR) -.82 (VR) - .26 (NA) - 1.27 (LU) + .54 (WK) + 1.98 (PS) - 1.50(MS)
Place (Pegs)	.56	66.64 - .36(MR) + .19 (SR) + .17 (VR) - .50(NA) - .64(LU)-.38(WK) + 2.24(PS) + 1.55(MS)
Turn (Pegs)	.53	73.37-.69 (MR) + .60(SR) + .98 (VR) - .41(NA) -.29(LU) + .37(WK) + 2.23(PS) + 1.50(MS)
Assembly (Rivets)	.50	15.82 + .12(MR) + .34(SR) + .61(VR)-.12(NA) -.20(LU)-.03(WK) + 1.05(PS) + .29(MS)
Disassembly (Rivets)	.57	18.46 + .19(MR) + .24(SR) + .39(VR)-.06(NA) -.05(LU)-.11(WK) + 1.09(PS) + .14(MS)

Abbreviations for CAPS scales: MR = Mechanical Reasoning; SR = Spatial Relations; VR = Verbal Reasoning; NA = Numerical Ability; LU = Language Usage; WK = Word Knowledge; PS = Perceptual Speed and Accuracy; MS = Manual Speed and Dexterity

SION (SPSS^X, 1986) program used for the analysis. In general, there were logical relationships between the CAPS scores entered and the GATB score being predicted. For example, the Perceptual Speed and Accuracy, Language Usage, and Numerical Abilities CAPS scales were entered to predict the GATB Name Comparison Scale. While Numerical Ability does not seem entirely logical, it only contributed 2% to the total explained variance of 51%.

Analysis of Residual Scores. Residual scores were examined in order to identify situations in which computing GATB scores from the CAPS based regression equations would lead to substantially inaccurate predictions. Residual scores are the algebraic difference between an actually obtained score and the score predicted by a regression equation. As might be anticipated, a regression to the mean phenomenon was noted in which extremely high GATB scores tended to be underestimated by the CAPS. Similarly, extremely low CAPS scores overestimated GATB scores. This finding was confirmed by plotting standardized scatterplots for each of the GATB scales in which z-scores of the residuals were plotted against test scores in z-score form. In every case, clearly linear relationships were observed with positive or negative residual scores increasing as the GATB score in question deviated from its sample mean. For illustrative purposes we present the scatterplots for the GATB Name Comparison, Three-Dimensional Space, and Assembly scales in Figures 1, 2 and 3. These scales were chosen in order to present representative data for a verbal test, a spatial ability test and a motor dexterity test. In each case the same linear pattern emerges, indicating that regression to the mean appears to be the major basis for predictive error.

DISCUSSION

The major conclusion based upon these multiple regression analyses is that reasonably accurate predictions of GATB subtest scores can be made on the basis of CAPS performance within the average range of abilities. Caution should be exer-

Table 3.
Stepwise Analyses: CAPS Scales Entered for Each GATB Scale and Increments in Explained Variance

GATB Scale	CAPS Scales Entered and % Increments in Explained Variance						
	Scale	%	Scale	%	Scale	%	Total %
Name Comparison	PS	38	LU	11	NA	2	51
Computation	NA	47	PS	7	WK	1	55
3-Dimensional Space	SR	34	VR	7	MR	6	47
Vocabulary	LU	51	WK	11	NA	1	63
Tool Matching	PS	36	VR	5			41
Arithmetic Reasoning	NA	39	WK	9	SR	3	51
Form Matching	PS	29	VR	9	SR	3	41
Mark Making	PS	33	MS	10	LU	7	50
Place (Pegs)	PS	24	MS	5			29
Turn (Pegs)	PS	20	MS	5	VR	2	27
Assembly (Rivets)	PS	18	VR	5			23
Disassembly (Rivets)	PS	27	SR	4			31

Abbreviations for CAPS scales: MR = Mechanical Reasoning; SR = Spatial Relations; VR = Verbal Reasoning; NA = Numerical Ability; LU = Language Usage; WK = Word Knowledge; PS = perceptual Speed and Accuracy; MS = Manual Speed and Dexterity

cised with regard to application of the regression equations presented when the CAPS scores are extremely high or low. If they are high, GATB scores will most likely be underestimated, while if they are low, the GATB scores will probably be overestimated. As indicated, this effect is a regression to the mean phenomenon.

While all of the Rs were highly statistically significant, there was some variation in percentage of explained variance. The multiple correlation coefficient for the GATB Vocabulary scale was .80; it was .50 for the GATB Assembly scale. Thus while robust multiple correlations were found in all cases, predictive confidence may be modified somewhat on the basis of their varying magnitudes.

It was encouraging to find in the stepwise analyses that there was a logical relationship between scales taken from the two batteries. For example, the first two CAPS scales entered into the regression equation for the GATB Vocabulary scale were the CAPS Language Usage and Word Knowledge scales. Correspondingly, the first CAPS variables entered for the GATB Disassembly scale were the Perceptual Speed and Spatial Relations scales. These results suggest that the CAPS and GATB assess similar ability domains, as was also pointed out by Katz et al. (1989).

Referring back to Katz et al's factor analyses, the CAPS variables entered into the regression equations for GATB scales that loaded on GATB factor 1, a verbal factor, also loaded on CAPS factor 1, also a verbal factor. A similar relationship was found for CAPS factor 3, a psychomotor factor. Scales loading on CAPS factor 2, the perceptual factor, provided substantial explained variance to the regression equation for the GATB 3-Dimensional Space scale, although CAPS factor 2 did not have an equivalent in Katz et al.'s factor analysis of the GATB.

In attempting to answer the question raised in the title of this paper concerning predicting GATB scores from CAPS scores, we would first note that there are strong conceptual relationships between the two aptitude batteries, in that they appear to assess comparable ability domains. However, with regard to prediction of scores in individual cases, some cautions should be exercised. First, the regression equations presented here should be used with caution, or should not be used at all when the CAPS profile consists of extremely high or low scores. If the profile is variable, estimates for high and low scores will probably be less accurate than they will be for average level scores. If the regression equations are used under these circumstances, one should understand that GATB estimates made from extremely high CAPS scores will tend to underestimate what the individual would obtain if he or she actually took the GATB, while the opposite is true for extremely low CAPS scores. Users of these tests may not wish to employ the regression equations in the case of clients known to be of exceptionally high or low intelligence. When an estimate of intelligence is not available and the client produces extreme CAPS scores, it may be desirable to administer the GATB. It is also suggested that more confidence can be placed in predictions made concerning the GATB pencil-and-paper tests than is the case for the performance tests. The Rs were higher for the former type of test.

These findings do not address themselves to the matter of whether the CAPS or the GATB has superior predictive validity in terms of vocational adjustment. They do, however

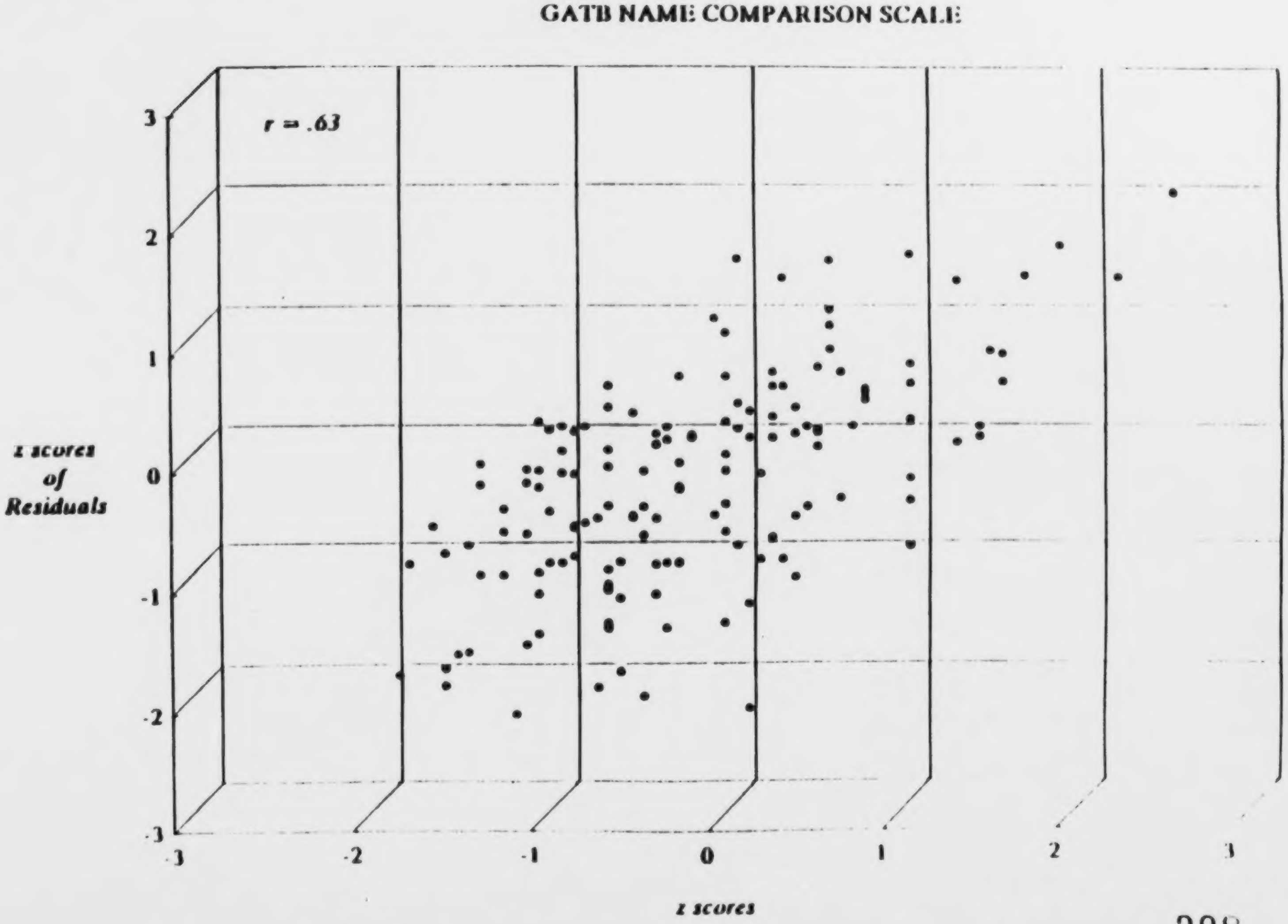

Figure 1
Standardized Scatterplot for GATB Name Comparison Scale. Z-scores of Residuals are Plotted Against Scale Scores in Z-score Form.

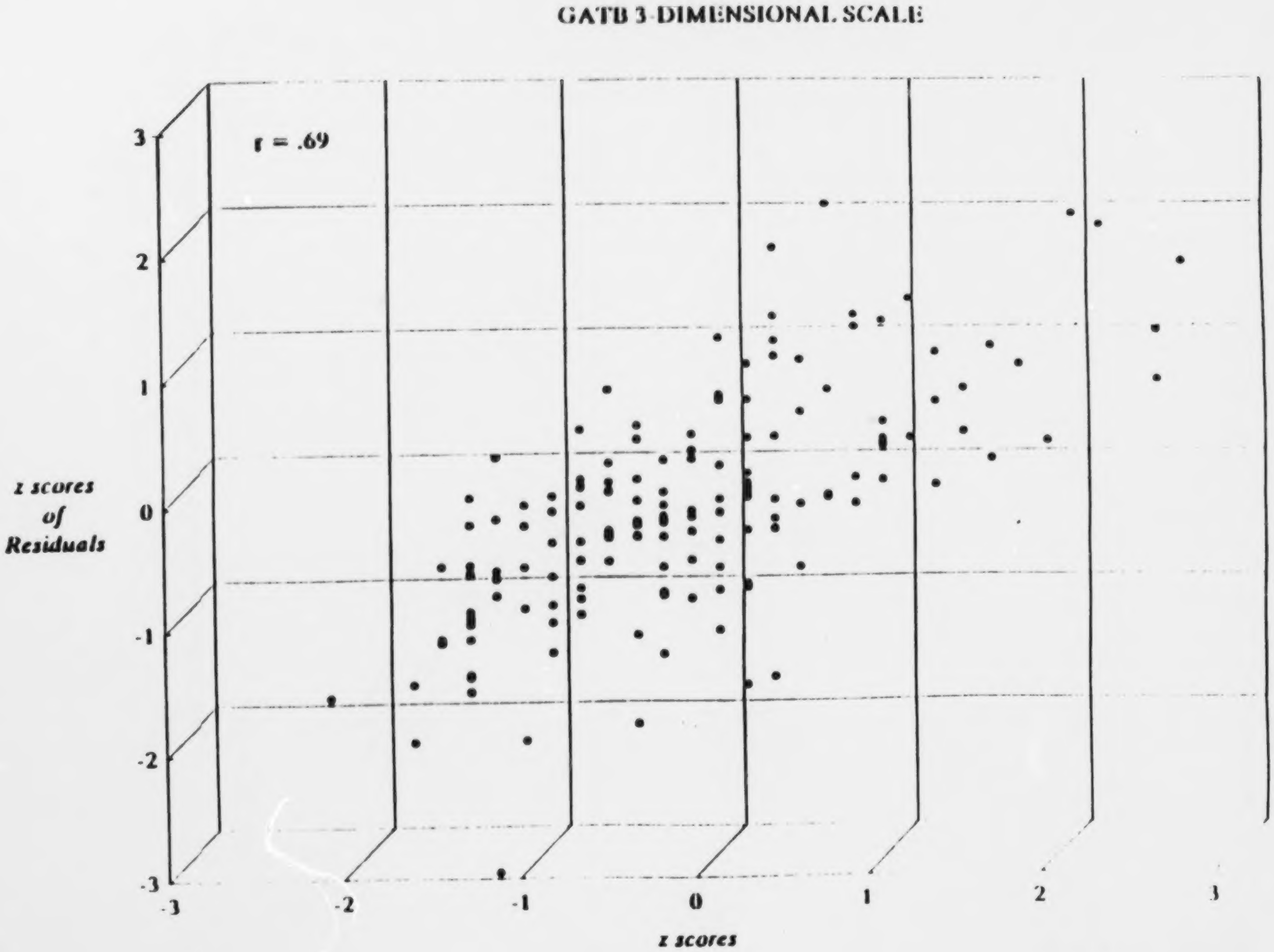

Figure 2
Standardized Scatterplot for GATB Three-Dimensional Space Scale. Z-scores of Residuals are Plotted Against Scale Score Z-score Form.

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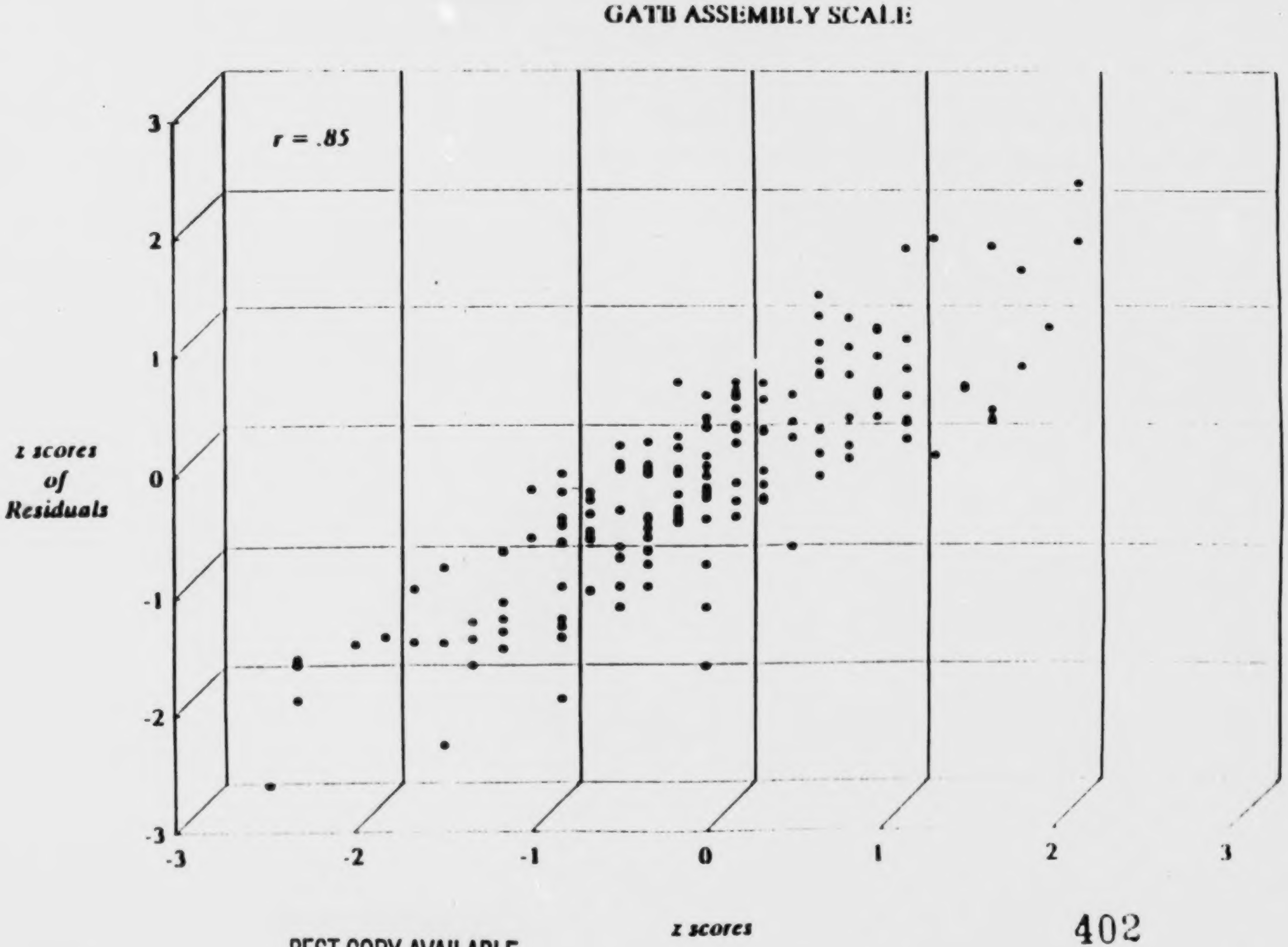

Figure 3
Standardized Scatterplot for GATB Assembly Scale Z-scores of Residuals are Plotted Against Scale Scores in Z-score Form

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indicate that both procedures assess roughly comparable domains of ability in psychiatric patients. Furthermore, the regression equations provided here allow, in appropriate cases, for making reasonably accurate estimates of GATB scores through the use of a briefer procedure with apparently greater clinical acceptability for psychiatric patients.

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Footnotes

1. Indebtedness is expressed to the Department of Veterans Affairs for support of this research.

2. Western Psychiatric Clinic utilized DSM-III rather than DSM-III-R (1987) at the time the diagnostic evaluations were accomplished.

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Adult Psychiatric Norms for the Career Ability Placement Survey (CAPS)

By Lynda J. Katz, Gerald Goldstein, Michelle Geckle, Judith Morrissey and Rosalind Daily

Abstract

Adult psychiatric patient norms are presented for the Career Ability Placement Survey (CAPS) based upon a sample of 500 psychiatric patients ranging in age from 14 thru 59. Separate norm tables are presented for the total sample, for subjects who completed 10 thru 12 years of education, and for subjects who received at least 1 year of college education. Statistically significant gender differences were found for some of the CAPS scales. A table providing separate norms for males and females is presented for those scales. It was noted that, in general, the patient norms obtained did not deviate greatly from the national norms.

The Career Ability Placement Survey (CAPS) (Knapp & Knapp, 1984) is widely used in vocational evaluations as a method of assessing employment relevant patterns of ability. It is similar in intent to other vocational assessment procedures such as the General Aptitude Test Battery (GATB) and the Differential Aptitude Test. It consists of eight scales: Mechanical Reasoning, Spatial Relations, Verbal Reasoning, Numerical Ability, Language Usage, Word Knowledge, Perceptual Speed and Accuracy and Manual Speed and Dexterity. Raw scores from each of these scales are converted to stanine scores, and may be plotted on an ability profile. The scores may also be plotted on the CAPS Career Profile Sheet allowing for comparison between scores obtained and ability levels required for fourteen major occupational areas.

The eight stanine scores form the basis for the information derived from the CAPS Career Profile Sheet, and ultimately for the portion of career planning that is based upon performance on the CAPS. The norms for setting the cutting points for the stanines were developed by testing large national samples of intermediate, high school and community college students. However, the CAPS may be used for adults no longer in school and in special populations of adults. The special population considered here is adults with psychiatric disabilities. Aptitude testing is commonly used for such individuals (Anthony & Jansen, 1984; Bidwell, 1969), but typically they are no longer in school when the tests are administered. Furthermore, certain characteristics associated with these indivduals' psychiatric disorders are capable of influencing performance on ability tests. Therefore, the fact that ability tests are administered to individuals who (1) are no longer in school and (2) have mental illness, may indicate that available national norms, despite their adequacy in a general student population, may not be appropriate for such individuals.

Inappropriate norms for an individual are generally conceived of as those that are based upon samples of subjects that are not composed of peers of the test-taker in some respect. In the case of ability tests, educational peers are generally used. However, in the case of the CAPS, the normative samples consisted of individuals currently in school, as opposed to psychiatric patient test-takers, who are usually assessed in clinical settings following completion of their educations. Furthermore, individuals with mental illness were not specifically represented in the CAPS national normative samples. A major consequence of inappropriate norms is disproportionate representation. Reschly (In Press) defines disproportionate representation as follows: "Disproportionate representation occurs whenever an identifiable group has significantly greater or fewer members in a particular classification than would be expected from their actual numbers or percentages in the general population" (p.155) In the case of the CAPS, that would translate to the possibility that individuals with psychiatric disorders may be classified into the various stanine groups in a distribution that is substantially deviant from what is found in the general population. While such classification may ultimately be predictive of actual vocational success, it may have unfortunate consequences for the counseling process, since the client's ability levels may be evaluated with reference to an inappropriate peer group.

It is not being suggested that the national CAPS norms are de facto inappropriate for psychiatric patients. However, that may be the case, and it would be worthwhile to evaluate the matter. If psychiatric norms are needed and developed, their availability would allow the counselor not only to assess the client's ability levels relative to the general population, but also relative to others no longer in school, and with disabilities or illnesses similar to her's or his. The CAPS was chosen for this study because of considerations raised in an article by Katz, Beers, Geckle and Goldstein (1989) in which it was pointed out that CAPS has psychometric and administrative advantages for psychiatric patients over the more commonly used GATB.

METHOD

Subjects

The sample consisted of 500 psychiatric patients referred to the Neuropsychological Assessment and Rehabilitation Services of Western Psychiatric Institute and Clinic for vocational evaluations. The large majority of subjects were in outpatient status, but a small number of them received their evaluations while still inpatients pending discharge. The sample's diagnostic composition appeared to be reasonably representative of general psychiatric facilities. The percentages in each major diagnostic category were as follows: organic mental disorders (3%); schizophrenic disorders (18%); mood disorders (30%); anxiety disorders (9%); personality disorders (5%); substance use disorders (3%); eating disorders (7%); adjustment disorders (10%); conduct disorders (5%); specific developmental disorders (3%); and other disorders originating in childhood (1%), with the remaining 6% having other miscellaneous diagnoses. There were 238 male and 262 female subjects. Three hundred and ninety-eight subjects were white, 94 were Afro-Americans, and the remainder belonged to other ethnic minority groups. The mean age was 28.23 years (SD = 10.22) with a range of 14 through 59 years of age. The mean educational level was 12.24 years (SD = 2.16), with a range of from 8 through 19 years of education.

Procedure

The CAPS was individually administered by trained specialists as part of a more comprehensive rehabilitation evaluation. Scoring was accomplished by computer and the results were entered into a data base. Protocols with incomplete data, or judged by the tester to be invalid, were not included in the study.

The major data analyses were directed toward producing tables comparable to those found in the CAPS manual (Knapp & Knapp, 1984) that convert raw scores on each of the eight scales to stanines. In the system used, the stanines are set at 4th, 11th, 23rd, 40th, 60th, 77th, 89th, 96th percentiles, and range from 1 representing very low performance to 9 representing very high performance. The manual contains conversion tables for each scale for individuals in grades 8-9, in grades 10-11-12, and in community college. In this study, tables were produced for subjects in grades 10-11-12, and for community college; there were not enough subjects to produce meaningful 8-9 grade tables. Subjects with less than a 10th grade education were included in the tables for the total sample of 500, but were excluded from the tables prepared for subjects with appropriate educational levels for the 10-11-12 grade and community college tables.

In addition to preparing separate education related tables, separate tables for females and males were constructed. The CAPS manual does not present separate norms for females and males, but the researchers were uncertain about the presence of significant gender differences in an adult psychiatric sample. A multivariate analysis of variance (MANOVA) was performed in order to evaluate the statistical significance of obtained gender differences. This analysis also examined data for the presence of a significant interaction between gender and educational level. In those cases in which statistically significant ($p<.05$) gender difference were found, separate conversion tables for females and males were constructed.

RESULTS

The Tables of Norms

The stanine score conversions for the total psychiatric sample and the CAPS manual 10-11-12 grade conversions are presented in Table 1. The 10-11-12 grade table was chosen for comparison because the mean educational level of the psychiatric sample (12.24 years) fell into that range. Inspection of Table 1 indicates only a modest discrepancy between the psychiatric and national sample norms. The direction

Table 1

CAPS Norms Study-Full Sample (N=500) - Comparisons Between National and Patient Norms[1]

Mechanical Reasoning

National Norms									
Scores	0-3	4-5	6	7-8	9	10-11	12-13	14-15	16-20
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-2	3-4	5	6	7	8-9	10-11	12-15	16-20
Stanines	1	2	3	4	5	6	7	8	9

Spatial Relations

National Norms									
Scores	0-4	5	6	7-8	9	10-11	12-13	14-15	16-18
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-3	4	5	6-7	8	9-10	11-12	13-14	15-18
Stanines	1	2	3	4	5	6	7	8	9

Verbal Reasoning

National Norms									
Scores	0-6	7-8	9-10	11-12	13-14	15-17	18-19	20-21	22-28
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-3	4-5	6-7	8-9	10-11	12-14	15-17	18-20	21-28
Stanines	1	2	3	4	5	6	7	8	9

Numerical Ability

National Norms									
Scores	0-5	6-7	8	9-10	11-12	13-15	16-17	18-19	20-24
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-4	5	6-7	8-9	10-11	12-13	14-16	17-18	19-24
Stanines	1	2	3	4	5	6	7	8	9

Language Usage

National Norms									
Scores	0-7	8-9	10-11	12-14	15-16	17-18	19-22	23-25	26-30
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-4	5-7	8-9	10-12	13-16	17-20	21-24	25-26	27-3[illegible]
Stanines	1	2	3	4	5	6	7	8	9

Word Knowledge

National Norms									
Scores	0-12	13-16	17-19	20-24	25-29	30-35	36-41	42-46	47-56
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-10	11-14	15-19	20-26	27-35	36-44	45-50	51-53	54-56
Stanines	1	2	3	4	5	6	7	8	9

Perceptual Speed & Accuracy

National Norms									
Scores	0-59	60-68	69-79	80-89	90-99	100-112	113-128	129-141	142-150
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-42	43-53	54-63	64-74	75-88	89-101	102-112	113-126	127-150
Stanines	1	2	3	4	5	6	7	8	9

Manual Speed & Dexterity

National Norms									
Scores	0-109	110-159	160-202	203-230	231-262	263-294	295-330	331-375	376-532
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-147	148-190	191-216	217-249	250-284	285-315	316-377	378-419	420-532
Stanines	1	2	3	4	5	6	7	8	9

[1] Grade 10-11-12 norms were used.

of the discrepancy varies from scale to scale. For example, in the case of the Mechanical Reasoning Scale, relatively lower scores were required by the psychiatric patients for assignment to particular stanines than was the case for the national sample. Thus, for example, psychiatric patients with scores of 10-11 were classed 7th stanine, while scores of 12-13 are required for the national sample. However, in the case of the Manual Speed and Dexterity Scale, the opposite relationship occurred. Here, for example, scores between 295 and 330 placed national sample subjects into the 7th stanine, while psychiatric patients required scores ranging between 316 and 377 for placement into that stanine.

Comparisons between patients and national sample subjects with high school level educations are presented in Table 2. Essentially the same relationship are seen here as was the case for the total sample. That is, the raw score to stanine conversions are not very deviant from each other in two samples, with scale to scale variations between patients and the national sample regarding whether or not relatively higher or lower score ranges are required for assignment to a particular stanine.

The community college data are presented in Table 3.

Table 2

CAPS Norms Study-Grades 10-11-12 (N=296)
Comparisons Between National and Patient Norms

Mechanical Reasoning

National Norms									
Scores	0-3	4-5	6	7-8	9	10-11	12-13	14-15	16-20
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-2	3-4	5	6	7	8	9-10	11-13	14-20
Stanines	1	2	3	4	5	6	7	8	9

Spatial Relations

National Norms									
Scores	0-4	5	6	7-8	9	10-11	12-13	14-15	16-18
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-3	4	5	6	7-8	9-10	11-12	13-14	15-18
Stanines	1	2	3	4	5	6	7	8	9

Verbal Reasoning

National Norms									
Scores	0-6	7-8	9-10	11-12	13-14	15-17	18-19	20-21	22-28
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-3	4-5	6	7-8	9-11	12-13	14-16	17-20	21-28
Stanines	1	2	3	4	5	6	7	8	9

Numerical Ability

National Norms									
Scores	0-5	6-7	8	9-10	11-12	13-15	16-17	18-19	20-24
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-3	4-5	6-7	8	9-10	11-12	13-14	15-17	18-24
Stanines	1	2	3	4	5	6	7	8	9

Language Usage

National Norms									
Scores	0-7	8-9	10-11	12-14	15-16	17-18	19-22	23-25	26-30
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-4	5-6	7-8	9-11	12-15	16-19	20-22	23-25	26-30
Stanines	1	2	3	4	5	6	7	8	9

Word Knowledge

National Norms									
Scores	0-12	13-16	17-19	20-24	25-29	30-35	36-41	42-46	47-56
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-11	12-14	15-17	18-24	25-30	31-40	41-46	47-51	52-56
Stanines	1	2	3	4	5	6	7	8	9

Perceptual Speed & Accuracy

National Norms									
Scores	0-59	60-68	69-79	80-89	90-99	100-112	113-128	129-141	142-150
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-42	43-53	54-63	64-73	74-86	87-96	97-110	111-125	126-150
Stanines	1	2	3	4	5	6	7	8	9

Manual Speed & Dexterity

National Norms									
Scores	0-109	110-159	160-202	203-230	231-262	263-294	295-330	331-375	376-532
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-142	143-189	190-216	217-250	251-280	281-314	315-354	355-416	417-532
Stanines	1	2	3	4	5	6	7	8	9

Table 3

CAPS Norms Study-Community College (N=155)
Comparisons Between National and Patient Norms

Mechanical Reasoning

National Norms									
Scores	0-3	4-5	6	7-8	9-10	11	12-13	14-15	16-20
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-2	3-4	5	6-7	8-9	10-11	12-14	15-16	17-20
Stanines	1	2	3	4	5	6	7	8	9

Spatial Relations

National Norms									
Scores	0-3	4-5	6	7-8	9	10-11	12-13	14-15	16-18
Stanines	1	2	3	4	5	6	7	8	9
Patient Norms									
Scores	0-4	5	6	7	8-10	11	12-13	14-15	16-20
Stanines	1	2	3	4	5	6	7	8	9

Verbal Reasoning

National Norms

Scores	0-6	7-8	9-10	11-12	13-15	16-17	18-19	20-21	22-28
Stanines	1	2	3	4	5	6	7	8	9

Patient Norms

Scores	0-4	5-6	7-8	9-11	12-13	14-15	16-18	19-22	23-28
Stanines	1	2	3	4	5	6	7	8	9

Numerical Ability

National Norms

Scores	0-5	6-7	8-9	10-11	12-13	14-15	16-17	18-19	20-24
Stanines	1	2	3	4	5	6	7	8	9

Patient Norms

Scores	0-5	6-7	8-9	10-11	12-13	14-16	17-18	19-20	21-24
Stanines	1	2	3	4	5	6	7	8	9

Language Usage

National Norms

Scores	0-8	9-10	11-12	13-15	16-18	19-21	22-23	24-25	26-30
Stanines	1	2	3	4	5	6	7	8	9

Patient Norms

Scores	0-7	8-10	11-13	14-17	18-20	21-24	25-26	27-28	29-30
Stanines	1	2	3	4	5	6	7	8	9

Word Knowledge

National Norms

Scores	0-15	16-20	21-25	26-31	32-38	39-43	44-46	47-49	50-56
Stanines	1	2	3	4	5	6	7	8	9

Patient Norms

Scores	0-17	18-21	22-30	31-39	40-45	46-49	50-53	54-55	56
Stanines	1	2	3	4	5	6	7	8	9

Perceptual Speed & Accuracy

National Norms

Scores	0-64	65-74	75-84	85-94	95-105	106-118	119-131	132-144	145-150
Stanines	1	2	3	4	5	6	7	8	9

Patient Norms

Scores	0-42	43-53	54-63	64-73	74-86	87-96	97-110	111-125	126-150
Stanines	1	2	3	4	5	6	7	8	9

Manual Speed & Dexterity

National Norms

Scores	0-125	126-170	171-210	211-240	241-270	271-310	311-340	341-385	386-532
Stanines	1	2	3	4	5	6	7	8	9

Patient Norms

Scores	0-140	141-190	191-220	221-249	250-292	293-326	327-385	386-440	441-532
Stanines	1	2	3	4	5	6	7	8	9

In this case, the decision was made to include all patients who completed one year or more of college education. Thus, some of the patients received more than a two year community college education. The reason for that decision was that no national norms are available for people with more than community college education, and so the national norm table for the community college group is the most appropriate one to use for individuals with advanced educations. It is therefore likely to be the one used by clinicians that administer the CAPS to adults who have more than two years of college education. Inspection of Table 3 indicates the same pattern as was seen in the other comparisons. The standards for stanine assignment in both the national sample and the patient group are more rigorous relative to the high school samples. For example, at the high school level, scores of 19-22 in the national sample or 20-22 in the patient sample are required for assignment to the 7th stanine on the Language Usage Scale. In the case of the community college table, the comparable values are 22-23 for the national sample and 25-26 for the patients.

Gender Differences

The CAPS manual does not contain separate norm tables for females and males; in this study, it was decided to examine the matter of possible gender differences on the various scales for the following reasons. First, the existence of known gender differences regarding certain of the abilities assessed by the CAPS has been documented (Mancoby & Jacklin, 1974). Secondly, while gender differences may not emerge in the child and young adult samples used for national norms, such differences may appear in relatively older adults.

The major statistical method used was a factorial design multivariate analysis of variance (MANOVA), with he CAPS scales as the dependent measures, and gender and education as the two factors, or independent variables. Subjects were divided into high and a low education group on the basis of a median split. Thus, subjects with 13 or more years of education were placed in the high education group, and the other subjects were placed in the low education group. Education was considered in order to rule out the possibility that apparent gender differences could be artifacts of gender differences in educational level. The results of the MANOVA are summarized in Table 4.

Table 4

MANOVA Results Comparing Subjects with Relatively High and Low Levels of Education and Female and Male Subjects

Effect	*Exact F (d.f. = 8/488)*	*p*
Education	18.71	<.001
Gender	17.11	<.001
Education X Gender	1.41	NS

Univariate F-Tests (d.f. = 1, 495)

Scale	*F (Ed.)*	*p*	*F (Ge.)*	*p*	*F(Ed. x Ge.)*	*p*
Mechanical Reasoning	19.57	<.001	31.30	<.001	.02	NS
Spatial Relations	22.10	<.001	2.51	NS	.02	NS
Verbal Reasoning	26.92	<.001	4.16	<.05	.16	NS
Numerical Ability	74.30	<.001	.00	NS	3.30	NS
Language Usage	107.66	<.001	41.55	<.001	4.04	<.05
Word Knowledge	113.43	<.001	5.01	<.05	.36	NS
Perceptual Speed & Accuracy	12.26	<.001	18.42	<.001	06	NS
Manual Speed & Dexterity	2.67	NS	6.68	<.01	1.49	NS

NS = not statistically significant; Ed. = Educational Level
Ge.= Gender

There are significant overall main effect for both educational level and gender. That is, males differed significantly from females on the multivariate series of CAPS scores, as did the higher education group from the lower education group. However, the overall education level by gender interaction was not statistically significant; this finding indicates that the gender differences found are not generally confounded with educational level. The only possible exception is the Language Usage scale in which there was a statistically significant interaction ($p < .05$) between gender and educational level. However, the absence of overall significance substantially vitiates the meaningfulness of that finding.

Significance tests for gender, educational, and interactional effects for the individual CAPS scales are also presented in Table 4. The education effect was statistically significant for all scales except the Manual Speed and Dexterity scale. Females were found to perform better than males at statistically significant ($p < .05$) levels on the Verbal Reasoning, Language Usage, Word Knowledge, Perceptual Speed and Accuracy, and Manual Speed and Dexterity scales. Males did significantly better than females only on the Mechanical Reasoning. A normative table presenting raw score to stanine conversions by gender for the sample is presented in Table 5.

Table 5

CAPS Norms Study - Comparisons Between 262 Female and 238 Male Patients For Those Scales On Which There Was A Statistically Significant (p<.05) Gender Differences

Mechanical Reasoning

Females

Scores	0-2	3-4	5	6	7	8	9	10-11	12-20
Stanines	1	2	3	4	5	6	7	8	9

Males

Scores	0-3	4	5-6	7	8-9	10	11-13	14-16	17-20
Stanines	1	2	3	4	5	6	7	8	9

Verbal Reasoning

Females

Scores	0-4	5	6-7	8-9	10-12	13-14	15-17	18-21	22-28
Stanines	1	2	3	4	5	6	7	8	9

Males

Scores	0-3	5	6-7	8	9-11	12-13	14-16	17-19	20-28
Stanines	1	2	3	4	5	6	7	8	9

Language Usage

Females

Scores	0-6	7-8	9-11	12-14	15-18	19-22	23-25	26-27	28-30
Stanines	1	2	3	4	5	6	7	8	9

Males

Scores	0-4	5	6-8	9-10	11-14	15-17	18-21	22-24	25-30
Stanines	1	2	3	4	5	6	7	8	9

Word Knowledge

Females

Scores	0-11	12-15	16-19	20-27	28-37	38-45	46-51	52-54	55-56
Stanines	1	2	3	4	5	6	7	8	9

Males

Scores	0-9	10-13	14-19	20-24	25-31	32-42	43-48	49-53	54-56
Stanines	1	2	3	4	5	6	7	8	9

Perceptual Speed & Accuracy

Females

Scores	0-47	48-59	60-67	68-81	82-93	94-104	105-114	115-132	133-150
Stanines	1	2	3	4	5	6	7	8	9

Males

Scores	0-38	39-47	48-60	61-72	73-81	82-94	95-108	109-120	121-150
Stanines	1	2	3	4	5	6	7	8	9

Manual Speed & Dexterity

Females

Scores	0-131	132-189	190-219	220-252	253-291	292-326	327-381	382-428	429-532
Stanines	1	2	3	4	5	6	7	8	9

Males

Scores	0-152	153-194	195-213	214-241	242-275	276-302	303-345	346-408	409-532
Stanines	1	2	3	4	5	6	7	8	9

DISCUSSION

The major purpose of this article is to present normative data on the CAPS for adult psychiatric patients. However, the data obtained would suggest that the norms developed with our 500 psychiatric patients do not differ substantially from those based upon the national sample. This finding is somewhat surprising in view of the widespread beliefs and extensive literature concerning cognitive impairments in individuals with chronic mental disorders. While in most cases lower raw scores were required for assignment to a particular stanine in the psychiatric sample relative to the national sample, sometimes the reverse occurred. For example, in the case of the high school norms (Table 2), the range of scores for assignment to the eight stanine of the Manual Speed and Dexterity scale is 331-375 for the national sample, but 355-416 for the patient sample. It is not being suggested that this difference is statistically or clinically significant, but it does indicate that the ability levels of the psychiatric sample were not uniformly underestimated because of utilization of an inappropriate normative sample. Thus, the patient norms presented here may be applied, but the CAPS user would not typically substantially overestimate or underestimate an adult psychiatric patient's capacities by utilizing the national sample norms. In effect, the present investigation supports the conclusion made by Katz et al. (1989) that the CAPS is a psychometrically satisfactory instrument for adult psychiatric patients.

Despite the fact that the patients were sometimes administered the CAPS long after they completed their educations, while the national sample consisted of individuals still in school, the impact of education was strong in both groups. For example, in the case of the Numerical Ability scale, in the national high school sample, a score of 11 or 12 is required for assignment to the fifth stanine, while a score of 12 or 13 is required for the community college sample. In the case of the patients, the comparable scores are 9 or 10 in the high school sample, and 12 or 13 in the college sample. Comparisons between Tables 2 and 3 provide a consistent pattern of educational influence in both the patient and national samples. It would therefore appear that education has an impact despite the length of time since its completion, and the presence or absence of a psychiatric disorder.

The significance of the gender differences found is apparently of some relevance, since it affects stanine assignment. Referring to Table 5, it will be noted, for example, that females require a score of 7 to be assigned to the fifth stanine of the

Mechanical Reasoning scale; males require a score of 8 or 9. Conversely, on the Language Usage scale, females require a score ranging between 15 and 18 to be assigned to the fifth stanine, while males only require scores ranging from 11 to 14. As demonstrated above, these differences cannot be readily attributed to educational differences between males and females in the sample.

In summary, while adult psychiatric patient norms for the CAPS have been provided, it seems apparent that the use of the national norms would not be misleading when applied to psychiatric patients. Furthermore, the influence of education on test performance appears to be of comparable magnitude in the national and the patient samples. Gender differences were noted on several of the CAPS scales, for the most part favoring females. Whether or not these differences appear in groups other than adult psychiatric patients cannot be answered by the present study, but might merit further investigation.

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THE MAJOR PSYCHIATRIC DISORDERS

SCHIZOPHRENIA

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SCHIZOPHRENIA IN THE 90'S

WHAT IS IT?

WHAT CAUSES IT?

HOW TO TREAT IT?

SCHNEIDERIAN FIRST RANK SYMPTOMS

1. AUDITORY HALLUCINATIONS IN WHICH THE VOICES SPEAK ONE'S THOUGHTS ALOUD
2. AUDITORY HALLUCINATIONS WITH TWO VOICES ARGUING
3. AUDITORY HALLUCINATIONS WITH THE VOICES COMMENTING ON ONE'S ACTIONS
4. HALLUCINATIONS OF TOUCH WHEN THE BODILY SENSATION IS IMPOSED BY SOME EXTERNAL AGENCY
5. WITHDRAWAL OF THOUGHTS FROM ONE'S MIND
6. INSERTION OF THOUGHTS INTO ONE'S MIND BY OTHERS
7. BELIEVING ONE'S THOUGHTS ARE BEING BROADCAST TO OTHERS, AS BY RADIO OR TELEVISION
8. INSERTION BY OTHERS OF FEELINGS INTO ONE'S MIND.
9. INSERTION BY OTHERS OF IRRESISTABLE IMPULSES INTO ONE'S MIND.
10. FEELING THAT ALL ONE'S ACTIONS ARE UNDER THE CONTROL OF OTHERS, LIKE AN AUTOMATION.
11. DELUSIONS OF PERCEPTION, AS WHEN ONE IS CERTAIN THAT A NORMAL REMARK HAS A SECRET MEANING FOR ONESELF.

DSM-III-R DIAGNOSTIC CRITERIA FOR SCHIZOPHRENIA

A. PRESENCE OF CHARACTERISTIC PSYCHOTIC SYMPTOMS IN THE ACTIVE PHASE FOR AT LEAST ONE WEEK

(1) TWO OF THE FOLLOWING DELUSIONS:

PROMINENT HALLUCINATIONS
INCOHERENCE OR LOOSENING OF ASSOCIATIONS
CATATONIC BEHAVIOR
FLAT OR INAPPROPRIATE AFFECT

(2) BIZZARE DELUSIONS

(3) PROMINENT HALLUCINATIONS, E.G., A VOICE WITH CONTENT HAVING NO APPARENT RELATION TO MOOD

BEST COPY AVAILABLE

B. FUNCTIONING IN SUCH AREAS AS WORK, SOCIAL RELATIONS, AND SELF-CARE IS MARKEDLY BELOW LEVEL ACHIEVED BEFORE ONSET OF THE DISTURBANCE.

C. SCHIZOAFFECTIVE DISORDER AND MOOD DISORDER HAVE BEEN RULED OUT.

D. CONTINUOUS SIGNS OF THE DISTURBANCE FOR AT LEAST SIX MONTHS - MUST INCLUDE AN ACTIVE PHASE WITH SYMPTOMS AS NOTED IN A, WITH OR WITHOUT A PRODROMAL OR RESIDUAL PHASE.

D. (con't.)

PRODROMAL OR RESIDUAL SYMPTOMS

MARKED SOCIAL ISOLATION OR WITHDRAWAL

MARKED IMPAIRMENT IN ROLE FUNCTIONING

PECULIAR BEHAVIOR

IMPAIRMENT IN PERSONAL HYGIENE

BLUNTED OR INAPPROPRIATE AFFECT

DIGRESSIVE, VAGUE, OVER ELABORATE, OR CIRCUMSTANTIAL SPEECH, OR POVERTY OF SPEECH, OR POVERTY OF CONTENT OF SPEECH

ODD BELIEFS OR MAGICAL THINKING

UNUSUAL PERCEPTUAL EXPERIENCES

MARKED LACK OF INITIATIVE, INTERESTS, OR ENERGY

E. IT CANNOT BE ESTABLISHED THAT AN ORGANIC FACTOR INITIATED AND MAINTAINED THE DISTURBANCE

F. IF THERE IS HISTORY OF AUTISTIC DISORDER, THE ADDITIONAL DIAGNOSIS OF SCHIZOPHRENIA IS MADE ONLY IF PROMINENT DELUSIONS OR HALLUCINATIONS ARE ALSO PRESENT

SCHIZOPHRENIA	> 6 MONTHS DURATION
	SUBTYPES
SCHIZOPHRENIFORM DISORDER	< 6 MONTHS DURATION
BRIEF REACTIVE PSYCHOSIS	< 2 WEEKS DURATION
SCHIZOAFFECTIVE DISORDER	
SCHIZOID PERSONALITY	} UNDER PERSONALITY DISORDERS
SCHIZOTYPAL PERSONALITY	

GOOD OUTCOME AND POOR OUTCOME GROUPS

1. HISTORY OF ADJUSTMENT PRIOR TO ONSET OF ILLNESS
2. FAMILY HISTORY
3. AGE OF ONSET
4. SUDDENNESS OF ONSET
5. PRECIPITATING EVENTS
6. CLINICAL SYMPTOMS

SCHIZOPHRENIA

1. IT IS A BRAIN DISEASE OR DISEASES, PROBABLY THE LATTER. THE BRAINS OF PEOPLE WITH SCHIZOPHRENIA ARE DIFFERENT FROM THE BRAINS OF PEOPLE WHO DO NOT HAVE SCHIZOPHRENIA.

2. THE AREA OF THE BRAIN WHICH IS RESPONSIBLE FOR SCHIZOPHRENIA APPEARS TO BE THE LIMBIC SYSTEM AND ITS CONNECTIONS.

3. SCHIZOPHRENIA TENDS TO RUN IN FAMILIES.

4. SOME CASES OF SCHIZOPHRENIA BEGIN WITH BRAIN DAMAGE VERY EARLY IN LIFE, PERHAPS EVEN BEFORE THE CHILD IS BORN, EVEN THOUGH THE SYMPTOMS OF THE DISEASE DO NOT BECOME MANIFEST UNTIL MANY YEARS LATER.

- 1/3 HAVE ABNORMALITIES OF BRAIN STRUCTURE
- ABNORMAL EEG'S ARE 4X MORE COMMON THAN IN PERSONS WITH DEPRESSION
- MULTIPLE ABNORMAL EYE MOVEMENTS
- DECREASED BLOOD FLOW TO FRONTAL LOBES
- DECREASED GLUCOSE UTILIZATION IN FRONTAL LOBES

THE LIMBIC SYSTEM

- DISTORTIONS IN PERCEPTION
- SCHIZOPHRENIC-LIKE SYMPTOMS IN OTHER DISEASES
- DOPAMINE/NOREPENEPHRINE LINKED TO SYSTEM
- LEFT HEMISPHERE

CROW'S TYPOLOGY

Type I -- positive symptom group

Type II -- negative symptom group

DOPAMINE THEORY

-- autoreceptor excess

-- postsynaptic receptor mechanism deficit

RECEPTORS (D_1 - D_5)

DOPAMINE SUBSYSTEMS

nigrostriatal
mesolimbic
mesocortical

hyperdopaminergia

hypodopaminergia

frontal lobe dysfunction = hypofrontality

hypodopaminergia -- mesocortical
dopamine neurons

hyperdopaminergia -- mesolimbic
dopamine neurons

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DEFICIT STATE SYMPTOMS

decreased plasma HVA

decreased CSF HVA

decreased prefrontal blood flow
during frontal tasks

POSITIVE SYMPTOMS

increased activity in A10

increased plasma HVA and positive symptoms

higher plasma HVA concentration
and responsiveness to neuroleptics

A Neurodevelopmental Approach to the Classification of Schizophrenia

by Robin M. Murray, Eadbhard O'Callaghan, David J. Castle, and Shon W. Lewis

Abstract

The conventional distinction between schizophrenia and manic depression has received little objective support from recent studies of phenomenology, outcome, or familial homotypy. Instead, much clinical, epidemiological, and morphological evidence suggests that within the broad range of Schneiderian schizophrenia there exists one form (congenital schizophrenia) that can be distinguished from other types, the manifestations of which are confined to adult life. We hypothesize that congenital schizophrenia is a consequence of aberrant brain development during fetal and neonatal life. Such patients show structural brain changes and cognitive impairment, and in their male predominance, early onset, and poor outcome, they reflect Kraepelin's original description of dementia praecox. We contend that adult-onset schizophrenia is itself heterogeneous. One important component is a relapsing and remitting disorder that is more frequent in females than in males, exhibits positive but not negative symptoms, and has much in common etiologically with affective psychosis. There also exists a very-late-onset group in which degenerative brain disorder is implicated.

In 1985 we put forward the view that it would soon be possible for psychiatry to move beyond the syndromal diagnosis of the psychoses (Murray et al. 1985*a*). In particular, we emphasized the value of distinguishing between genetic and environmental causes, and we suggested that the structural brain abnormalities found in a portion of sporadic cases of schizophrenia were consequences of environmental hazards operating during fetal or neonatal life.

Since that time, neuropathologic and neuroimaging research into schizophrenia has continued apace, and it is now commonplace to interpret the findings in neurodevelopmental terms (Feinberg 1983; Weinberger 1987; Murray et al. 1988; Cannon et al. 1989). Evidence of etiological heterogeneity has accumulated, and the different presentation of schizophrenia in males and females has aroused much interest. However, lines of research into genetics, epidemiology, brain abnormality, and gender differences have continued along largely separate paths and have not been integrated into a coherent theory. This article sets out to rally this new evidence and consider a theoretical framework in which it can be understood.

The Present Position

There is little agreement about what constitute the essential features of schizophrenia. Until recently, most European psychiatrists believed that Schneider's first-rank symptoms represented the core of schizophrenia and could be used to distinguish it from other psychotic disorders. However, first-rank symptoms occur in a substantial minority of patients with affective psychosis (Carpenter et al. 1973; Wing and Nixon 1975), while first-rank symptoms are not exhibited at all by almost a third of schizophrenic patients (Mellor 1970; Koehler 1979), and the presence of such symptoms has no predictive value (Brockington et al. 1978). Furthermore, sophisticated statistical

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approaches have failed to find a point of rarity between the clinical manifestations of schizophrenia and those of manic depression (Kendell and Gourlay 1970; Kendell and Brockington 1980).

An Inevitable Deterioration? In contrast to the broader Schneiderian criteria popular in Europe, American diagnostic criteria for schizophrenia have been narrowed so that they may better predict a course of progressive deterioration as described by Kraepelin (Murray and Foerster 1987). However, recent followup studies cast doubt on this pessimistic view of outcome. These studies have been comprehensively reviewed by Shepherd and colleagues (1989), but table 1 summarizes a number of those studies of long-term outcome in schizophrenia that used adequate samples (50 subjects or more) and included a majority of first-episode cases. As can be seen, most studies found that about a fourth of the cases showed good clinical and social recovery. Poor outcome is less easy to define, but all but one of the studies reported poor outcome in less than 50 percent of cases.

In examining the other side of the Kraepelinian coin, it is by no means clear that patients with affective disorder have an invariably good prognosis. Clayton (1981) suggested that as many as a third of bipolar patients have a poor outcome. Akiskal (1982) found that 26 percent of patients with primary depressive illness became social invalids, while Paykel and Weissman (1973) reported that poor social outcome was not uncommon. Lee and Murray (1988), who carried out an 18-year followup of 89 hospitalized primary depressive patients, noted that 35 percent had "very poor outcome," while 13 percent had subsequent episodes of schizoaffective disorder and 7 percent developed either chronic paranoid or schizophrenic psychoses.

When viewed collectively, the studies that have been mentioned suggest that the outcome in schizophrenia is not as bleak as Kraepelin believed, while that of affective psychosis is worse than he envisioned.

Genetic Validity? Many studies have confirmed that schizophrenia is familial (Murray et al. 1986; McGuffin et al. 1987), one of the most rigorous being that of Kendler and colleagues (1985). However, Kendler and colleagues reported that bipolar disorder occurred twice as frequently among the relatives of schizophrenic patients as among the relatives of a control group. There is also compelling evidence from family interview studies (Gershon et al. 1988) and family history studies (Foerster et al. 1991*b*) that morbid risk of unipolar affective disorder is higher in the relatives of probands with schizophrenia.

Furthermore, a number of large pedigrees containing some individuals affected by schizophrenia and others by bipolar affective disorder have been reported (Waddington and Youssef 1988; St. Clair et al. 1989; Pope and Yurgelun-Todd 1990). Diagnostic overlap also occurs in twin and triplet studies. For example, McGuffin and colleagues (1984, 1987) reviewed the Maudsley monozygotic (MZ) twin series originally described by Gottesman and Shields (1972) and noted the occurrence of five pairs in which the proband was diagnosed as having *DSM-III* (American Psychiatric Association 1980) schizophrenia,

Table 1. Long-term outcome of schizophrenia

Reference	Number of subjects	Average length of followup (years)	Functioning adequately without psychotic symptoms (%)	Intermediate (%)	Functioning poorly (e.g., prolonged hospitalization or suicide) (%)
Bleuler (1972)	208	5–23	30	34	35
Strauss and Carpenter (1972)	85	2	24	56	20
Tsuang et al. (1979)	200	35	20	25	55
Ciompi (1980)	282	37	36	40	23
Huber et al. (1980)	502	8–28	22	40	35
McGlashan (1984)	163	15	14	46	41
Harding et al. (1987)	253	20	26	37	38
Westermeyer and Harrow (1984)	153	3–5	21	21	45

yet the second twin received a diagnosis of affective disorder according to *DSM-III*.

Ødegård (1972) showed that it was those schizophrenic probands "without registered defect" (i.e., schizoaffective and allied conditions) whose relatives had an increased risk of affective psychosis. Relatives of schizophrenic probands "with severe defect" had a much lower risk of affective psychosis and a higher risk of schizophrenia. These data are consonant with many other studies. For example, McCabe and colleagues (1971) reported a morbid risk for affective disorder of 10 percent in the first-degree relatives of "good prognosis schizophrenia" but only 1.5 percent in the relatives of "poor prognosis schizophrenia." The pattern of morbid risk for schizophrenia was reversed in the relatives of good and poor-prognosis probands (3.6% and 11.6%, respectively). Pope and Lipinsky (1978, p. 817) concluded that "schizophrenics of the good prognosis categories show typically two to three times as much familial affective illness as schizophrenia; poor prognosis groups show a two to threefold difference in the opposite direction."

Kendler and Tsuang (1988), reviewing all published studies on the effect of schizophrenia or affective disorder in a relative on the prognosis of schizophrenia in the proband, including the Iowa 500 sample (Morrison et al. 1972), concluded that a family history of affective disorder confers a good outcome. In their own Iowa 500 sample, morbid risk of affective disorder was significantly higher in the relatives of good-outcome schizophrenic patients than in those with a poor outcome, who actually had lower family risk of affective disorder than was found in surgical control probands.

A study of MZ twins diagnosed by the Research Diagnostic Criteria (RDC; Spitzer et al. 1978) showed that the MZ co-twins of schizoaffective probands tended to be diagnosed as either suffering from schizoaffective disorder or major affective disorder but only rarely as schizophrenic or schizotypal personality disorder (SPD) (Murray et al. 1984; Murray and O'Callaghan 1991). On the other hand, the co-twins of schizophrenic probands were more frequently diagnosed with schizophrenia or SPD than as having schizoaffective or major affective disorder. The implication is that genetically RDC schizoaffective disorder is relatively distinct from RDC schizophrenia and that the latter is more closely related genetically to SPD than to affective disorder.

Six studies have shown increased rates of SPD in the relatives of *DSM-III*-defined schizophrenic patients (e.g., Kendler 1988). Furthermore, Kety and colleagues (1978) found rates of SPD in the relatives of adoptees with acute schizophrenia that were substantially lower than the rates in the relatives of adoptees with chronic schizophrenia. In their reanalysis using *DSM-III* criteria, Kendler and Gruenberg (1984) found SPD no more common in the biologic relatives of adoptees with atypical or schizophreniform disorders than in the relatives of control adoptees.

All of these studies are consistent with the notion that the appropriate genetic distinction is not between schizophrenia and affective psychosis but rather between acute schizophrenia, schizoaffective disorder, and affective psychosis on the one hand and chronic schizophrenia and SPD on the other. As Kety (1980, p. 426) states, "The group of acute functional psychoses differs so much from classical schizophrenia that it is difficult to see what advantage inheres in our continuing to confound them."

Summary of the Present Position. The distinction between manic depression and schizophrenia in terms of phenomenology, outcome, and familial homotypy is flawed. The evidence we have reviewed suggests that the failure to establish a valid subdivision of the psychoses is a consequence of the distinction being made at the wrong point, and that Kraepelin's original narrow concept of dementia praecox represents a much more distinct entity than the modern notion of schizophrenia.

Unfortunately, dementia praecox became subsumed in a wider range of disorders that resemble it in Schneiderian symptomatology but differ markedly in etiology, epidemiology, and brain morphology. It is notable that the only group able to distinguish statistically between the clinical manifestations of schizophrenia and other psychiatric disorders used a much narrower concept of schizophrenia than is generally accepted (Cloninger et al. 1985). Schizophrenia, as defined by these authors, was familial and had a poor outcome, leading the authors to conclude that they had validated the disease concept.

Neurodevelopmental Deviance in Schizophrenia

Early Development. The histories of schizophrenic patients are characterized by an excess of obstetric complications (OCs) versus normal controls and other psychiatric patients (McNeil and Kaij 1978; Lewis and Murray 1987). Furthermore, schizophrenic patients with a history of OCs develop the disorder an average of 5 years earlier than those without such a history (Lewis et al. 1989). OCs are particularly associated with chronic rather than acute remitting schizophrenia (McNeil and Kaij 1978; Parnas 1990; Foerster et al. 1991*a*).

Murray and colleagues (1985*a*) suggested that OCs may be one of several environmental factors that may act independently to predispose individuals without an obvious genetic predisposition to the subsequent development of schizophrenia. An alternative view is that OCs may be an indirect indicator of some earlier insult to the nervous system or a secondary consequence of some genetic defect in neural development (Goodman 1988; Owen et al. 1988). The latter explanation seems unlikely given the lower frequency of OCs in schizophrenic patients with, rather than without, a family history of the disorder (Lewis and Murray 1987).

There is also evidence that maternal influenza during pregnancy can increase the risk to the fetus of later developing schizophrenia. Studies in Finland (Mednick et al. 1988) and England (O'Callaghan et al. 1991) have shown that after the 1957 pandemic of Asian flu there was a significant increase in the number of births of individuals who later developed schizophrenia. The "schizophrenogenic effect" of influenza epidemics is not confined to Asian flu; influenza epidemics in Denmark (Barr et al. 1990) and England (Sham et al., in press) over four and two decades, respectively, had a consistent risk-increasing effect on those individuals in the later part of their fetal life during the epidemic. Presumably, maternal influenza or some factor associated with it causes a subtle impairment of brain development in the fetus.

The excess of abnormal dermatoglyphic patterns and minor physical anomalies (MPAs) in schizophrenic patients (Gualtieri et al. 1982; Guy et al. 1983; Green et al. 1987) provides a further indication of developmental disruption. These trivial abnormalities in ectodermal development are of little consequence in themselves, but ectodermal development during fetal life closely parallels that of the central nervous system, and MPAs are known to occur in excess in patients with established developmental disorders (Smith 1976). Green and colleagues (1987, 1989) found MPAs to predict a younger age of onset of schizophrenia, while Waddington and colleagues (1990) reported that MPAs were more common among those who are cognitively impaired.

Premorbid cognitive dysfunction in schizophrenia is another important yet underresearched piece in this developmental jigsaw puzzle. In a comprehensive review, Aylward and colleagues (1984) concluded that preschizophrenic children showed deficits on standard IQ tests versus matched groups of peers or siblings with no later psychiatric disorder. Moreover, such deficits predicted early-onset, poor-prognosis illnesses.

Kraepelin had little doubt that some individuals with dementia praecox had behaved differently, even as children, from their siblings and peers. Recently, in a controlled, blind study that interviewed the mothers of 73 *DSM-III*-diagnosed psychotic patients, Foerster and colleagues (1991*b*, 1991*c*) confirmed the occurrence of childhood schizoid and schizotypal traits and poor social adjustment in a proportion of schizophrenic patients. Those schizophrenic patients who were abnormal as children had an early onset of psychosis and were characterized by either a family history of schizophrenia or a history of OCs or low birth weight.

Structural Brain Abnormality. Neuropathologic studies (Bogerts et al. 1985; Brown et al. 1986) show that, compared with control subjects, schizophrenic patients have slightly lighter brains and smaller temporal lobe structures, usually with an absence of gliosis (Bruton et al. 1990). Recently, Falkai and colleagues (1990) confirmed Jakob and Beckmann's (1986) findings of heterotopic pre-alpha cells in the entorhinal cortex of postmortem schizophrenic brains; both groups interpret these findings to be consequences of failure of neuronal migration. Since the migration of these cells is largely complete by birth, such findings suggest a developmental, rather than a degenerative, pathology.

Neuropathologic studies have, by necessity, been carried out on samples too small and patients too poorly documented to correlate clinical findings with structural changes. However, neuroimaging studies have been able to address this issue. Thus, it has been demonstrated that the cerebral ventricular enlargement found in a proportion of schizophrenic patients is not the result of treatment (Johnstone et al. 1976; Williams et al. 1985), is present at the onset of illness (Nyback et al. 1982; Weinberger et al. 1982), is nonprogressive in most cases, and may be associated with poor premorbid adjustment (Weinberger et al. 1980; Williams et al. 1985). Harvey and colleagues (1992), who found a diffuse reduction in the volume of cortical gray matter in schizophrenic patients on magnetic resonance imaging (MRI), reported that this reduction was associated with poor premorbid function.

Several studies have compared ventricular size in familial versus sporadic schizophrenic patients. The studies in which a difference was found have generally found sporadic schizophrenic patients to have larger ventricles than familial schizophrenic patients, although the results have not been consistent (Murray et al. 1988; Lewis 1990). However, the important role of environmental factors has been put beyond doubt by studies of MZ twins discordant for schizophrenia (Reveley et al. 1982; Murray et al. 1985*b*; Suddath et al. 1990), showing that the affected twin has larger ventricles and less temporal lobe volume than the identical but well co-twin. It is not surprising that investigators have sought to establish whether the occurrence of OCs might be the critical factor. Of 10 studies that have looked for an association between quantitative computed tomography (CT) abnormalities and a history of OCs, 5 have found a statistically significant link (Lewis 1990). This point is impressive in view of the high chances of a Type 2 error as a result of low rates of OCs in most of these studies and the constraints on reliability of the data. It seems likely that OCs are one of a number of early environmental factors associated causally with ventricular enlargement. Maternal influenza may be another (O'Callaghan et al. 1991; Sham et al., in press).

Since only a subset of schizophrenic patients demonstrate structural brain changes, investigators have attempted to find the clinical parameters of this subpopulation. One of the most consistent findings is that of cognitive impairment (Johnstone et al. 1976), but significant relationships have also been reported with negative symptoms (Andreasen et al. 1982; Pearlson et al. 1984*a*), a poorer response to neuroleptics (Luchins et al. 1984), and poor outcome (Williams et al. 1985). The fact that not all studies have confirmed these relationships may relate to the heterogeneity of schizophrenia. Johnstone and colleagues (1989*a*) noted that deficits in cognitive function were correlated with decreased brain area only in patients with early-onset psychosis. Early onset was also associated with poor academic and occupational performance and with negative symptoms. It is, therefore, notable that the prealpha cell abnormalities reported by Jakob and Beckmann (1986) and Falkai and colleagues (1990) were seen particularly in patients who presented before age 25.

Thus, there appears to be a subgroup of schizophrenic patients who demonstrate morphological brain changes that antedate the development of the positive clinical syndrome. These brain changes signify early developmental deviance and occur most commonly among those with poor premorbid adjustment, evidence of cognitive impairment, early onset, and poor outcome (Murray et al. 1988). The existence of such developmental abnormalities does not, of course, exclude the possibility that some schizophrenic patients, particularly those with onset in late life, have anatomic changes of a degenerative nature (Pearlson et al. 1991).

Do Acute Psychotic Patients Have Evidence of Neurodevelopmental Abnormality?

Affective Psychosis. Now that it is clear that a proportion of patients with schizophrenia have neurodevelopmental impairment, it is incumbent upon us to ascertain whether the same holds for affective psychosis. To our knowledge, there have been no systematic studies of MPAs in patients with affective disorder. There have been few studies of OCs or of premorbid personality in such patients, but the previously-mentioned study of Foerster and colleagues (1991*b*, 1991*c*) did address both these issues. Evidence of OCs having occurred was obtained for 40 percent of probands with schizophrenia but for only 7 percent of probands with affective psychosis. Childhood personality and adjustment were unremarkable among those who went on to develop affective psychosis. Similarly, soft neurological signs are uncommon in patients with affective disorder (Woods et al. 1986), and O'Callaghan and colleagues (personal communication 1991) failed to find any relationship between exposure to influenza epidemics in fetal life and later affective disorder.

What of those other findings that have been associated with neurodevelopmental abnormality in schizophrenia? Unfortunately, the only substantial neuropathologic study of affective psychosis is that of Brown and colleagues (1986), who compared the brains of 26 schizophrenic patients with those of 41 unipolar depressive and 29 bipolar patients. The schizophrenic patients had larger cerebral ventricles, their brains were 6 percent lighter, and their parahippocampal cortices were 11 percent thinner than those of the patients with affective disorder. The schizophrenic patients showed dilation of the temporal horn of the lateral ventricle, but no such change was noted among the patients with affective disorder.

A number of CT and MRI studies have been carried out in patients with affective psychosis, but many of these studies have been concerned with elderly patients (Jacoby and Levy 1980) or with severe or resistant forms of the disorder (Standish-Barry et al. 1982; Targum et al.

1983; Luchins et al. 1984; Pearlson et al. 1984*a*, 1984*b*; Shima et al. 1984; Dolan et al. 1985; Roy-Byrne et al. 1988). Studies of more representative samples show that structural abnormality is less common in affective disorder than in schizophrenia. For example, Shettar and colleagues (1990) found no difference in temporal and hippocampal volume between depressed patients and controls; this finding contrasts with those of Suddath and colleagues (1989), who reported that schizophrenic subjects have less temporal volume than controls. Similarly, Johnstone and colleagues (1989*b*) reported that, while temporal lobe structures of manic-depressive patients, as determined by MRI, did not differ from controls, schizophrenic patients differed significantly from both controls and manic-depressive patients.

In contrast to schizophrenia, when structural abnormalities do occur in affective psychosis, they are associated with late rather than early onset (Jacoby and Levy 1980; Shima et al. 1984). Indeed, Sacchetti and colleagues (1990) suggest that when ventricular enlargement occurs in affective disorder, it does so in late-onset cases in which the affective disorder may be a manifestation of some primary brain disorder such as cerebral vascular disease. Pearlson and colleagues (1989) found both cognitive abnormalities and structural abnormalities to be a function of age in depressives. Direct evidence of the latter has come from our own controlled CT study of a consecutive series of psychotic patients under 50 years of age. The 43 *DSM-III* schizophrenic patients in the sample had a mean age at first admission of 22.7 years; age showed no correlation with ventricle brain ratio (VBR) (Spearman's rho = 0.07, NS). On the other hand, the 24 patients with affective psychoses had a mean age of first admission of 24.8 years; age correlated positively with VBR ($r = 0.60$; $p = 0.002$).

Acute Schizophrenia. Thus, affective psychosis differs from early-onset, poor-outcome schizophrenia in that only the latter shows evidence of neurodevelopmental abnormality. But what about that third group of patients variously described as suffering from schizoaffective disorder, schizophreniform disorder, or acute or good-prognosis schizophrenia?

In terms of clinical manifestations such as abrupt onset, florid symptoms, good response to neuroleptics, and good outcome, these patients share many characteristics with affective psychotic patients. Such patients are also similar to affective psychotic patients in having an unremarkable childhood personality and in rarely having a history of OCs (McNeil and Kaij 1978; Parnas 1990; Foerster et al. 1991*b*, 1991*c*). Good-outcome schizophrenic patients seldom show cognitive impairment. For example, Lindenmeyer and colleagues (1989) found that 35 RDC schizoaffective patients showed significantly less cognitive abnormality than a comparison group of 35 RDC schizophrenic patients, matched for age and duration of illness.

We noted earlier that the rates of schizoaffective and affective disorder in the relatives of good-outcome schizophrenic patients are high, while rates of chronic schizophrenia and SPD are low. Schizophrenic patients with a relative who suffers from bipolar affective illness are especially likely to show affective symptoms during their own acute illness, to have a good outcome (Kendler and Tsuang 1988), and to have few residual symptoms in remission (Kendler and Hays 1983). Furthermore, Owen and colleagues (1988, 1989), have shown that schizophrenic patients with a family history of affective disorder are less likely to have enlarged cerebral ventricles than are other schizophrenic patients. Other CT studies also suggest that good-outcome schizophrenic patients are less likely to have ventricular enlargement than chronic schizophrenic patients (Kolakowska et al. 1985).

Gender

Males with schizophrenia have a far worse outcome than females (Salokangas and Stengard 1990) and more frequently exhibit classic and negative symptoms of schizophrenia (Lewine 1981; Goldstein and Link 1988; Castle and Murray 1991*a*). Males with schizophrenia have more cognitive (Haas et al. 1990) and neurologic abnormalities (Marcus et al. 1985) and more MPAs (Waddington et al. 1990). They also show more premorbid IQ (Aylward et al. 1984) and personality abnormalities (Foerster et al. 1991*b*, 1991*c*) and earlier onset of schizophrenia than females (Angermeyer and Kuhn 1988; Lewine 1988; Haas et al. 1990); the latter is not a consequence of the manner in which age of onset is defined (Loranger 1984; Häfner et al. 1989).

Although the incidence of broadly defined schizophrenia (e.g., according to International Classification of Diseases [ICD-9; World Health Organization 1978] guidelines) is equal in the sexes, when narrowly defined criteria such as *DSM-III* or those of Feighner and colleagues (1972) are applied, the incidence appears much higher in males than in females. Castle et al. (1991*b*) have shown that this gender difference is accounted for by an excess of severe schizophrenia among young (and not older) males, and that those young male schizophrenic patients are especially likely to have shown premorbid abnormalities of personality and social adjustment.

It is interesting, therefore, that males with schizophrenia are more likely than their female counterparts to have a history of OCs (Wilcox and Nasrallah 1987; Pearlson et al. 1989; Foerster et al. 1991*b*, 1991*c*). Furthermore, males are more likely to exhibit structural brain abnormalities than females; Castle and Murray (1991*a*) reviewed 10 imaging studies (6 CT and 4 MRI) that report this. Bogerts and colleagues (1990) also found that the brains of male schizophrenic patients showed more neuropathologic abnormalities than those of their female counterparts.

It has recently become apparent that schizophrenia in females appears to be under greater genetic influence than male schizophrenia. Thus, the first-degree relatives of females with schizophrenia are at greater risk of psychosis than the relatives of males with schizophrenia (Bellodi et al. 1986; Goldstein et al. 1990; Pulver et al. 1992); similarly, female MZ twins have higher concordance rates than their male counterparts (Rosenthal 1970; Kringlen 1987).

Female schizophrenic patients have more affective symptoms than males (Castle and Murray 1991*a*). Further evidence of shared characteristics of female schizophrenic and affective psychotic patients comes from work concerning the season of the year when psychotic patients are admitted. It has long been known that patients with mania are more likely to be admitted to hospital during the hot summer months. However, in a study of first-admission patients in England and Wales, Takei and colleagues (in press) have shown that acute schizophrenic and paranoid schizophrenic patients (but not the more chronic subtypes) have similar seasonality of admission; the summer peak is shared by female but not by male schizophrenic patients. These data suggest that a proportion of schizophrenic patients, particularly females with acute schizophrenia, and manic patients are subject to similar causal or precipitating factors.

These findings lead to the conclusion that sex differences in schizophrenia reflect the fact that a lower proportion of female than male patients have the neurodevelopmental, early-onset, and poor-outcome type (Castle and Murray 1991*a*). In contrast, female schizophrenic patients show more similarities to affective psychotic patients than do male schizophrenic patients.

Neurodevelopmental Classification of Schizophrenia

Kraepelin (1893) did not originally include catatonic and paranoid deteriorating conditions in the category of dementia praecox, which he reserved for a severe condition predominantly affecting young men. In the 1896 edition of his textbook he indicated that dementia praecox was three times more common in men than in women, the majority of cases presented by age 22 years, and only 5 percent to 6 percent of patients admitted to his clinic suffered from dementia praecox. However, Kraepelin became persuaded that catatonia and paranoid deterioration were variants of dementia praecox. As a result of including these conditions, the sex distribution of the disorder became equal and the mean age of onset rose.

Subsequently, Bleuler (1911/1950) and then Schneider (1959) enlarged the concept of schizophrenia further by basing their diagnosis on phenomenology rather than on course and outcome. In the words of Berner (1991, p. 220), doing so resulted in a "tremendous extension of the boundaries of schizophrenia." Berner points out that in recent decades even German-speaking psychiatrists have become disillusioned with the Schneiderian concept of schizophrenia. His own view is that first-rank symptoms can arise not only in schizophrenia but also in affective psychosis and in paranoid psychoses. Berner's Vienna Research Criteria result in a much narrower concept of "endogenomorphic schizophrenia," with a marked male predominance.

We agree that the modern concept of schizophrenia is too broad and suggest that it needs to be "unbundled." We believe that a classification of the functional psychoses based on a developmental principle would help toward achieving this goal. Such a classification would subdivide schizophrenia into three main groups: congenital schizophrenia, adult-onset schizophrenia, and late-onset schizophrenia.

Congenital Schizophrenia. By definition this term implies that abnormality is present, although not necessarily recognizable, at birth. We postulate that this type may arise as a consequence of a genetic defect that results in decreased cortical volume and smaller temporal lobe structures, which are visualized by neuroimaging and seen in postmortem evidence of migration failure of the pre-alpha cells in the entorhinal cortex (Jones and Murray 1991). A similar clinical and neuropathologic picture may also result from early environmental hazard or some combinations of genetic predisposition and environmental hazard. The insults that have been implicated include maternal influenza, OCs, and perhaps early brain injury and infections. What these insults have in common is their occurrence at an early point of neurodevelopment.

Patients with congenital or neurodevelopmental schizophrenia are more likely to have evidence of MPAs and to have shown abnormal personality or social impairment in childhood. Such individuals present to the psychiatric services early, exhibit negative symptoms, and show morphological brain changes and cognitive impairment. In their clinical presentation (age of onset, male predominance, and poor outcome), these patients reflect the original description of dementia praecox by Kraepelin.

Adult-Onset Schizophrenia. Our contention is that many patients who exhibit Schneiderian symptoms and are currently classified under the category of schizophrenia are not suffering from dementia praecox. Such patients have little in common etiologically with cases of dementia praecox and lack the developmental attributes of congenital schizophrenia. Adult-onset schizophrenia probably encompasses several distinct conditions, but its subclassification is not yet clear.

The most numerous patients within the group appear to be those individuals with a disorder that is genetically related to affective disorder. In essence, we postulate that there exists an adult-onset psychotic disorder in which the phenotypic expression of the mutant gene or genes ranges from classic manic depression through schizoaffective disorder to acute schizophrenia.

This concept of a relapsing and remitting psychosis, capable of producing not only affective but also "positive" schizophrenic symptoms, owes much to the work of Berner (1991). Furthermore, like the Vienna school, we conclude that many patients with first-rank symptoms cannot be assigned to either dementia praecox or affective psychosis. Such cases include the paranoid psychoses and the drug-induced psychoses.

It may be argued that the neurodevelopment of patients with adult onset is unlikely to have been entirely normal, or why else would they have reacted to circumstances or drugs in such an abnormal way? We would rejoin that while such patients may eventually be found to show deviant neurotransmitter or neurophysiologic patterns of developmental origin, they show no evidence of the grosser "neurologic" abnormalities found in the congenital cases.

Late-Onset Schizophrenia. The foregoing discussion leaves unresolved the place of late-onset schizophrenia, or late paraphrenia. Such patients usually present after the age of 60 and have good premorbid functioning in the intellectual and occupational spheres. It is implausible, therefore, that they suffer from a neurodevelopmental disorder. Further factors suggesting that late paraphrenic patients are distinct from the congenital cases include a massive excess of females in almost all studies (see Harris and Jeste 1988), paranoid rather than schizotypal premorbid personality (Kay and Roth 1961; Post 1966; Kay et al. 1976), and an association with auditory and visual sensory deficit (Cooper 1976; Kay et al. 1976).

Family studies of late paraphrenia (reviewed by Castle and Murray, in press) are fraught with methodological shortcomings but tend to show rates of schizophrenia in siblings that are intermediate between those for younger probands and the general population. Furthermore, rates of affective disorder in relatives are high (Post 1966), compatible with the notion that some late paraphrenic patients have an illness etiologically related to the affective psychoses.

Recently, attention has focused on the evidence that a significant number of late paraphrenic patients show evidence of intellectual decline (Holden 1987) and that MRI studies have revealed excessive white-matter changes in some such patients (reviewed by Castle and Murray, in press). A number of studies have shown a higher VBR in late-onset schizophrenic patients, than in control subjects (Naguib and Levy 1987; Rabins et al. 1987; Jeste and Harris 1990) and suggested that this finding reflects some underlying degenerative cerebral pathology.

Thus, those patients labeled "late paraphrenic" form a heterogeneous group, some having an illness relating to paranoid personality, some to sensory deprivation, some to affective illness, and some to late-onset organic change. Organic brain dysfunction is increasingly being recognized as the underlying "final common pathway" in many such patients (Castle and Murray, in press).

Conclusion

The pillars supporting the Kraepelinian dichotomy of the functional psychoses are crumbling. There are two main interpretations of the relevant data. The first is that schizophrenia and manic depression are a single disorder lying along a continuum with a single etiology. Our interpretation is diametrically opposed to such a view. We contend that several genetic and environmental etiologies underlie the functional psychoses but that a crucial distinction exists between those cases with neurodevelopmental etiology (congenital schizophrenia) and those other forms, the manifestations of which are confined to adult life.

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Dopamine in Schizophrenia: A Review and Reconceptualization

**Kenneth L. Davis, M.D., René S. Kahn, M.D., Grant Ko, M.D.,
and Michael Davidson, M.D.**

Objective: The initial hypothesis that schizophrenia is a manifestation of hyperdopaminergia has recently been faulted. However, several new findings suggest that abnormal, although not necessarily excessive, dopamine activity is an important factor in schizophrenia. The authors discuss these findings and their implications. Method: All published studies regarding dopamine and schizophrenia and all studies on the role of dopamine in cognition were reviewed. Attention has focused on post-mortem studies, positron emission tomography, neuroleptic drug actions, plasma levels of the dopamine metabolite homovanillic acid (HVA), and cerebral blood flow. Results: Evidence, particularly from intracellular recording studies in animals and plasma HVA measurements, suggests that neuroleptics act by reducing dopamine activity in mesolimbic dopamine neurons. Post-mortem studies have shown high dopamine and HVA concentrations in various subcortical brain regions and greater than normal dopamine receptor densities in the brains of schizophrenic patients. On the other hand, the negative/deficit symptom complex of schizophrenia may be associated with low dopamine activity in the prefrontal cortex. Recent animal and human studies suggest that prefrontal dopamine neurons inhibit subcortical dopamine activity. The authors hypothesize that schizophrenia is characterized by abnormally low prefrontal dopamine activity (causing deficit symptoms) leading to excessive dopamine activity in mesolimbic dopamine neurons (causing positive symptoms). Conclusions: The possible co-occurrence of high and low dopamine activity in schizophrenia has implications for the conceptualization of dopamine's role in schizophrenia. It would explain the concurrent presence of negative and positive symptoms. This hypothesis is testable and has important implications for treatment of schizophrenia and schizophrenia spectrum disorders.

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When initially conceived, the dopamine hypothesis of schizophrenia posited that schizophrenic illness is a manifestation of a hyperdopaminergic state (1). The foundation of this hypothesis was mainly indirect evidence gained from the study of dopamine antagonists and agonists. Specifically, the ability of neuroleptics to displace dopamine antagonists in vitro robustly correlates with the clinical potency of these agents (2, 3). Conversely, drugs that increase dopamine activity generally worsen the symptoms of schizophrenia (4–7). In the last decade faults with the dopamine hypothesis have been described as data have accumulated that are inconsistent with the notion of hyperdopaminergia in all schizophrenic patients. For example, a substantial proportion of schizophrenic patients are resistant to treatment with neuroleptics, suggesting that other neurochemical systems may have a pathogenetic role in these patients. Furthermore, schizophrenic-like symptoms are rarely, if ever, induced in nonschizophrenic individuals when they are administered drugs that augment dopaminergic activity. Moreover, neuroleptics are only partially effective in alleviating the negative, or deficit, symptoms of schizophrenic patients (8), particularly after resolution of the acute phase of the illness. This, in turn, suggests that deficit state symptoms may be unrelated to excessive dopamine activity. It has also become evident that a hypothesis of excessive dopamine activity in all brain regions of schizophrenic patients is untenable. The results of post-mortem (9–14) and cerebrospinal fluid

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TABLE 1. Post-Mortem Studies of Dopamine and HVA Concentrations in Brains of Schizophrenic Patients[a]

		Results		
Study	Subjects	Site	Dopamine or HVA	Comparison
Reynolds (12)	SCZ (N=22), NC (N=19)	Amygdala	Dopamine	SCZ>NC; SCZ: left>right
Bacopoulos et al. (14)	SCZ–on (N=18–25), SCZ–off (N=3), NC (N=20–28)	Temporal cortex	HVA	SCZ–on>SCZ–off=NC
		Cingulate cortex	HVA	SCZ–on>SCZ–off=NC
		Frontal cortex	HVA	SCZ–on>SCZ–off=NC
		Putamen	HVA	SCZ=NC
Toru et al. (30)	SCZ–on (N=5), SCZ–off (N=5), NC (N=10)	Caudate	Dopamine	SCZ–on=SCZ–off=NC
			HVA	SCZ–on>SCZ–off=NC
		Accumbens	Dopamine	SCZ–on=SCZ–off=NC
			HVA	SCZ–off>SCZ–on=NC
Mackay et al. (31)	SCZ (N=34), NC (N=37)	Accumbens	Dopamine	SCZ>NC
		Caudate	Dopamine	SCZ=NC
Owen et al. (32)	SCZ (N=15), NC (N=15)	Caudate	Dopamine	SCZ>NC
		Accumbens	Dopamine	SCZ=NC

[a] SCZ=schizophrenic patients, NC=normal comparison subjects; "on" and "off" indicate whether or not the patients were receiving neuroleptic treatment.

CSF) (15) studies of dopamine metabolites do not make a convincing case for a homogeneous dopamine excess in schizophrenia. However, several new findings have rekindled the enthusiasm for a dopaminergic mechanism in schizophrenia:

1. Cortical abnormalities consistent with hypodopaminergic function and their possible relationship to deficit state symptoms.
2. A reciprocal relationship between cortical hypodopaminergia and subcortical hyperdopaminergia.
3. A relationship between the concentration of the dopamine metabolite homovanillic acid (HVA) in plasma, schizophrenic symptoms, and responsiveness to neuroleptics.

All these findings, both supporting and refuting a role for dopamine in schizophrenia, will be reviewed in this article. They warrant a reconsideration of the relationship between dopaminergic activity and schizophrenia.

HYPERDOPAMINERGIA

Problems

The initial evidence that abnormally high dopamine activity is a pathogenetic mechanism in schizophrenia was the correlation between potency of dopamine receptor blockade and clinical efficacy of neuroleptics. However, the finding that clozapine, the only neuroleptic proven clinically effective for schizophrenic patients who are relatively refractory to other neuroleptics (16), displays one of the weakest D_2 receptor binding affinities (2, 17, 18) challenges the hypothesis that neuroleptics are effective by virtue of their D_2 receptor blockade alone. Clozapine's affinity for D_2 receptors is one-tenth that of chlorpromazine (2, 17, 18), but in the studies comparing clozapine to chlorpromazine (16, 19–22) clozapine was more effective than chlorpromazine, generally at one-half the dose. Moreover, it has been consistently found that chronic administration of clozapine does not increase $[^3H]$spiroperidol binding in brain tissue (23–28), implying that it does not increase D_2 receptor sensitivity. Since dopamine antagonists increase D_2 receptor sensitivity after chronic administration, D_2 blockade by clozapine must be minimal. Significantly, despite this apparent lack of potent D_2 blockade, clozapine is a very (if not the most) effective antipsychotic.

Measurement of CSF concentrations of HVA provide additional evidence that a simple excess of dopamine activity is not associated with schizophrenia. A large number of studies measuring CSF HVA have been conducted and have been reviewed elsewhere (15). Many drug-free schizophrenic patients have normal or low CSF HVA concentrations (15, 29). One of the few consistent findings is that HVA concentration negatively correlates with the degree of cortical atrophy and ventricular enlargement. Since CSF HVA levels are affected by the site of lumbar puncture, motor activity, time of day, season, age, sex, height, and diet and since most studies have not controlled for some of these factors, it is difficult to interpret these data. Nevertheless, the results of CSF studies suggest that a homogeneous excess of dopamine (metabolism) as reflected in CSF is certainly not present in schizophrenia. However, post-mortem studies examining dopamine and HVA concentrations and dopamine receptors provide more compelling evidence of dopaminergic abnormalities in schizophrenia.

Post-Mortem Studies

As shown in table 1, the HVA and dopamine concentrations in post-mortem brains of schizophrenic patients consistently show differences from the brains of normal subjects. However, the differences in the anatomical areas where the abnormalities are found are not consistent. For example, the concentrations of HVA in the caudate nucleus and nucleus accumbens

TABLE 2. Post-Mortem Studies of Dopamine Receptor Densities in Brains of Schizophrenic Patients[a]

Study	Subjects	Site	Ligand	Results	
				Receptor	Comparison
Toru et al. (30)	SCZ–on (N=5), SCZ–off (N=5), NC (N=10)	Putamen	$[^3H]$Spiperone	D_2	SCZ–on>NC, SCZ–off>NC
Mackay et al. (31)	SCZ–on (N=9), SCZ–off (N=3), NC (N=17)	Caudate	$[^3H]$Spiperone	D_2	SCZ–on>NC, SCZ–off=NC
Seeman et al. (33)	SCZ–on (N=92), NC (N=242)	Striatum	$[^3H]$Spiperone	D_2 D_1	SCZ–on>NC SCZ–on=NC
Crow et al. (34)	SCZ–on (N=14), SCZ–off (N=5), NC (N=19)	Caudate	$[^3H]$Spiroperidol	D_2	SCZ–on>NC, SCZ–off>NC
Cross et al. (35)	SCZ–on (N=8), SCZ–off (N=7), NC (N=8)	Caudate	$[^3H]$Flupenthixol	D_2 D_1	SCZ–on=SCZ–off>NC SCZ=NC
Hess et al. (36)	SCZ (N=8), NC (N=8)	Caudate	$[^3H]$Spiperone	D_2 D_1	SCZ>NC SCZ<NC

[a] SCZ=schizophrenic patients, NC=normal comparison subjects; "on" and "off" indicate whether or not the patients were receiving neuroleptic treatment.

(30) and cortex (14) have been found to be higher in the brains of schizophrenic patients than in normal brains. The difference in caudate concentration was attributable to prior medication, while the finding in the accumbens applied only to the medication-free patients. Similarly, although one study (31) showed the dopamine concentration in the accumbens to be higher in schizophrenic patients than in comparison subjects, another study (32) showed more dopamine in the caudate of schizophrenic patients but not in the accumbens. Finally, Reynolds (12) reported excessive dopamine in the amygdala of schizophrenic patients, with the greatest excess in the left hemisphere. These inconsistencies may be due to differences in the medication status of the patients studied, varying analytical and statistical methods, or genuine anatomical specificity of dopamine abnormalities in schizophrenia.

Although not indicative of greater than normal dopamine turnover or activity, D_2, but not D_1, receptors have generally been found to be abnormally prevalent in the striatum of schizophrenic patients. Table 2 summarizes the dopamine receptor studies performed to date. These results have often been dismissed as simply reflecting neuroleptic treatment. However, most studies of patients who have been neuroleptic-free for at least 1 year before study or are drug naive show that these patients also have more striatal D_2 receptors than normal subjects. Other evidence from post-mortem studies, as well as preclinical pharmacological investigations, buttresses the argument that D_2 receptor excesses are not merely the result of neuroleptic treatment. A bimodal distribution of D_2 receptors in the brains of schizophrenic patients who have received neuroleptics indicates that neuroleptics do not uniformly increase D_2 receptor numbers in schizophrenic patients (33). The number of excess striatal dopamine receptors due to neuroleptic pretreatment in experimental animals is one-half of the difference between post-mortem tissue from schizophrenic and normal subjects (30, 31, 33–35). Rodents treated with neuroleptics have 30% more D_2 receptors than untreated rodents, whereas the brains of schizophrenic patients have 50% to 60% more D_2 receptors than those of normal subjects. Neuroleptic-treated patients with Alzheimer's disease or Huntington's disease have 25% more striatal dopamine receptors than do comparison subjects, whereas the number for schizophrenic patients exceeds that of comparison subjects by more than 100% (33), providing suggestive evidence that neuroleptics account for only some of the excess of D_2 receptors seen in schizophrenia. One study (36) showed greater D_2 receptor density but lower D_1 receptor density in the caudate nuclei in schizophrenic patients than in normal subjects. Thus, the available data strongly suggest that D_2 (but not D_1) receptor density is higher than normal in schizophrenia and that this finding cannot be totally accounted for by medication history.

Positron Emission Tomography Studies

Positron emission tomography (PET) measurements of in vivo D_2 receptor affinity in humans have provided conflicting results. One group who studied 10 neuroleptic-naive schizophrenic patients and 11 healthy comparison subjects, using $[^{11}C]$methylspiperone as a D_2 ligand, found more D_2 receptors in the patients than in normal comparison subjects (37). In contrast, when 15 (38) and 18 (39) similarly drug-naive schizophrenic patients were studied with $[^{11}C]$raclopride, D_2 receptor density did not differ between the patients and normal subjects. However, an asymmetry in D_2 receptor density was found in the schizophrenic but not the normal subjects: D_2 receptor density was higher in the left than in the right putamen (39). When $[^{76}Br]$bromospiperone was used to compare D_2 receptor density

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in 12 schizophrenic patients (who either were drug naive or had been drug free for at least 1 year) and 12 comparison subjects, no group differences in D_2 receptor density were found (40). However, the more acutely ill patients had a greater D_2 receptor density in the striatum than the more chronically ill patients or the comparison subjects, suggesting that D_2 receptor density may be state dependent. The conflicts in the data may be partially due to differing ligands. For instance, methylspiperone, but not raclopride, binds potently to 5-HT_2 receptors. Moreover, the methods with which the PET data were analyzed varied across studies. Finally, as the study using [^{76}Br]bromospiperone suggests, differences in patient groups may partly explain the different D_2 receptor densities found in schizophrenic patients. These data lead to no firm conclusions at this time.

Mechanism of Action of Neuroleptics

The original notion that hyperdopaminergia is a pathogenetic mechanism in schizophrenia was, at the very least, too imprecise. For instance, there are multiple types of dopamine receptors. D_1 receptors, which are coupled to adenylate cyclase, have a low affinity for [^{3}H]spiperone and are located in the cortex of humans (41, 42). D_2 receptors are negatively associated with adenylate cyclase, display a great affinity for [^{3}H]spiperone (43), are most prominent in the striatal and limbic structures in humans, and, if present at all in the human cortex, have a low density (42, 44). The D_2 receptor has recently been cloned, and two D_2 subreceptors, labeled D_{2a} and D_{2b}, have been identified (45–50). The elucidation of the pharmacological, anatomical, and physiological differences between D_{2a} and D_{2b} receptors will add further complexity to the conceptualization of dopamine neurotransmission and further weaken any simplistic notions linking the action of neuroleptics to a unitary effect on all dopamine receptors. The cloning of a dopamine receptor (51) anatomically limited to limbic areas and resembling neither D_1 nor D_2, and consequently named D_3, underscores the fact that the initial simplistic perception of the dopamine system urgently needs to be revised. Questions remain about which dopamine receptors are most critical to modulating the symptoms of schizophrenia, where they are located, and how they differ from dopamine receptors that are irrelevant to the actions of neuroleptics. Of particular interest in this regard are the recently cloned D_4 and D_5 receptors (52, 53). D_4 receptors have a higher affinity for the atypical neuroleptic clozapine and thus have extraordinary implications for the development of a new generation of antipsychotic drugs. D_5 receptors resemble D_1 receptors but have a higher affinity for dopamine.

Anatomically, the dopamine system consists of a number of subsystems: nigrostriatal, mesolimbic, and mesocortical. The nigrostriatal system projects from the substantia nigra (also called A9) to the neostriatum (i.e., putamen and caudate). The mesolimbic system has its cell bodies in the ventral tegmental area (also called A10) of the midbrain and in the substantia nigra and projects to the accumbens, olfactory tubercle, and amygdala. The mesocortical system has its cell bodies mainly in the ventral tegmental area, and its neurons project to the prefrontal cortex, as well as to the accumbens, septum, and olfactory tubercles (54, 55). The effects of neuroleptics on these different dopamine neuronal systems are not equivalent. A single dose of a neuroleptic increases dopamine neuron firing in the nigrostriatal and mesolimbic dopamine systems (56, 57). This is probably due to blockade of presynaptic D_2 receptors and subsequent decreased inhibition of dopamine activity (57, 58). Chronic (3–4 weeks) neuroleptic administration decreases dopamine neuron firing in both A9 and A10 to below pretreatment levels, and this decrease can be reversed by apomorphine; this phenomenon is called depolarization blockade (58, 59). Atypical neuroleptics, i.e., antipsychotics that do not induce extrapyramidal side effects, such as clozapine, are anatomically more selective in their effect on dopamine neuronal firing than typical neuroleptics in that they induce depolarization blockade in A10 only (57–64). The particular affinity of clozapine for D_4 receptors suggests that important differences among dopamine receptors can account for some aspects of clozapine's atypicality. On the basis of these data, it has been proposed that depolarization blockade in A9 is responsible for the induction of extrapyramidal effects, while depolarization blockade in A10 leads to the antipsychotic effects of neuroleptics (61). Thus, these studies suggest that excess dopamine activity in A10, and not a general excess of dopamine activity, may be related to psychosis.

Thus, the data so far reviewed suggest that the antipsychotic effects of neuroleptics are related to a decrease in firing in *specific* dopaminergic neurons (i.e., A10) and, by inference, that schizophrenia may be related to excessive activity of these, and therefore not all, dopaminergic neurons. This possibility underscores the imprecision of the initial hypothesis that schizophrenia is related to excessive dopamine function in general. This point is made even more poignant by the elucidation of numerous dopamine receptor subtypes, whose specific roles in the modulation of schizophrenic symptoms remain unknown and are a critical area for future research.

Plasma HVA

The finding that depolarization blockade in A10 is a characteristic of all neuroleptics suggests that a decrease in dopamine firing (in A10) may be an important mechanism of action of antipsychotics. However, obtaining direct evidence linking the antipsychotic effect of neuroleptics to their effect on dopamine cell firing in humans has been impossible. Therefore, indirect measurements of dopamine activity must be obtained. Plasma levels of the dopamine metabolite HVA may be such a measure. The HVA found in plasma is

TABLE 3. Studies of Plasma HVA Concentrations in Schizophrenic Patients Before Neuroleptic Treatment[a]

Study	Subjects	Mean Weeks Without Drug	Correlation of Plasma HVA With Clinical Rating or Between-Groups Difference in Plasma HVA Level
Maas et al. (69)	SCZ (N=23)	2	BPRS: r=0.38, NPR: r=0.49
Pickar et al. (71)	SCZ (N=11)	5	NPR: r=0.81
Sharma et al. (72)	SCZ (N=11), PSY (N=6)	2.5	BPRS: r=−0.08
Davis et al. (73)	SCZ (N=18)	4	CGI: r=0.66
Davidson and Davis (74)	SCZ (N=14), NC (N=14)	3	CGI: r=0.51, BPRS: r=0.49; SCZ<NC
Pickar et al. (75)	SCZ (N=8)	2	NPR: r=0.82, BPRS: r=0.49
Van Putten et al. (76)	SCZ (N=22)	4	BPRS: n.s.
Kirch et al. (77)	SCZ (N=22)	6	BPRS: n.s.

[a]SCZ=schizophrenic patients, PSY=patients with various psychoses, NC=normal comparison subjects, BPRS=Brief Psychiatric Rating Scale, NPR=Nurses Global Psychosis Rating, CGI=Clinical Global Impression rating scale.

TABLE 4. Studies of Plasma HVA Concentrations in Schizophrenic Patients During Neuroleptic Treatment[a]

Study	Subjects	Duration of Treatment	Drug and Daily Dose	Plasma HVA Change or Correlation of HVA Change With Change in Clinical Rating
Davidson et al. (66)	SCZ (N=30)	6 weeks	Haloperidol, 20 mg	Increase at day 1
Pickar et al. (71)	SCZ (N=16)	5 weeks	Fluphenazine, 30 mg	Decrease at weeks 3–5; ΔNPR: r=0.89
Sharma et al. (72)	SCZ (N=11), PSY (N=6)	4 weeks	Trifluoperazine, 40 mg	Same at week 4; ΔBPRS: r=0.67
Davila et al. (78)	SCZ (N=14)	4 weeks	Haloperidol, 10 mg	Increase at day 4; ΔBPRS: r=−0.61
Bowers et al. (79)	PSY (N=37)[b]	9 days	Perphenazine, 0.5 mg/kg, or haloperidol, 0.2 mg/kg	Decrease at days 7–9
Bowers et al. (80)	PSY (N=29)[c]	10 days	Haloperidol, 0.2–0.4 mg/kg	Level in responders higher than in nonresponders at baseline and 4–6 days, decreased by days 19–21
Wolkowitz et al. (81)	SCZ (N=12)	10 weeks	Fluphenazine, 27 mg, plus alprazolam, 2.9 mg	Decrease in responders, increase in nonresponders
Chang et al. (82)	SCZ (N=33)	6 weeks	Haloperidol, 20 mg	Level in good responders higher than in poor responders at baseline, decreased at weeks 2–6; increase in nonresponders at 1–2 weeks
Davidson et al. (83)	SCZ (N=20)	5 weeks	Haloperidol, 20 mg	Level in responders higher than in nonresponders at baseline; no change in nonresponders, decrease in responders

[a]SCZ=schizophrenic patients, PSY=patients with various psychoses, NPR=Nurses Global Psychosis Rating, BPRS=Brief Psychiatric Rating Scale.

[b]Only four patients were schizophrenic.

[c]Only two patients were schizophrenic.

produced primarily by brain dopamine neurons and peripheral noradrenergic neurons. Secondary sources of HVA are peripheral dopamine and brain noradrenergic neurons. Animal and human studies (65–67) suggest that brain dopamine turnover is reflected by plasma HVA concentrations. Although the precise proportion of plasma HVA deriving from brain HVA has not been fully elucidated (68, 69), measurement of this dopamine metabolite in plasma of schizophrenic patients appears to be a valid method for investigating dopamine activity in this disorder provided certain conditions are met (70).

The results of studies on plasma HVA in humans are shown in tables 3–5. These findings are consistent with animal data, that is, neuroleptics initially increase and subsequently decrease dopamine firing. Thus, plasma HVA concentrations rise dramatically during the first few days of neuroleptic treatment (66, 78). This rise in plasma HVA coincides with the increase in striatal dopamine firing observed in animals after acute administration of neuroleptics. After chronic (1 week or more) administration of neuroleptics, plasma HVA levels decrease to below baseline levels (71, 79), which is consistent with the depolarization blockade observed in animals after chronic administration of neuroleptics.

Indeed, studies examining plasma HVA concentrations in relation to response to neuroleptic treatment suggest an association between the effects of neuroleptics on dopamine activity and treatment outcome. The initial increase (78) and the subsequent decrease (71, 72, 80–83) after administration of neuroleptics are as-

TABLE 5. Studies of Plasma HVA Concentrations in Schizophrenic Patients After Discontinuation of Neuroleptic Treatment[a]

Study	Subjects	Weeks Since Drug Discontinuation	Plasma HVA Change or Correlation of HVA Change With Change in Clinical Rating
Pickar et al. (71)	SCZ (N=11)	5	Increase at week 5; ΔNPR: r=0.81
Davidson et al. (84)	SCZ (N=24)	6	Greater change in relapsers than nonrelapsers; ΔBPRS: r=0.49
Glazer et al. (85)	SCZ (N=13)	3	Greater change in relapsers than nonrelapsers
Kirch et al. (77)	SCZ (N=22)	6	Same at week 6

[a] SCZ=schizophrenic patients, NPR=Nurses Global Psychosis Rating, BPRS=Brief Psychiatric Rating Scale.

sociated with clinical response to this treatment. Conversely, clinical decompensation after discontinuation of neuroleptic treatment is associated with increases in plasma HVA levels (71, 84, 85).

The suggestion that the therapeutic effects of neuroleptics are due to a decrease in dopamine activity is further supported by plasma HVA studies showing that greater severity of illness in schizophrenia is related to greater dopamine turnover. As table 3 indicates, several studies have found a positive correlation between plasma HVA level and clinical severity (73–75). Three studies (72, 76, 77) did not confirm this finding. The most likely explanation for the different results across studies is the number of plasma HVA samples taken as a basis for the correlational studies. The studies using more than one sampling of plasma HVA found significant positive correlations between plasma HVA and severity of symptoms, whereas studies using a single measurement of plasma HVA did not. The studies producing significant correlations between plasma HVA and severity of schizophrenic symptoms averaged three (75), four (73), or 13 (74) plasma HVA samples, whereas the studies that produced negative findings (72, 76, 77) assessed plasma HVA only once. Repeated plasma HVA measurements in the same individual therefore appear to increase the signal-to-noise ratio for plasma HVA by reducing the intraindividual variance in plasma HVA concentration.

However, the relationship between plasma HVA and schizophrenic illness is not straightforward. In one study (74), plasma HVA levels were lower in chronic, treatment-resistant schizophrenic patients than in normal subjects, although plasma HVA levels still correlated with symptom severity. Such results are consistent with the data derived from a study of urinary catecholamines in a similar group of chronically institutionalized patients (86), in whom lower levels of urinary catecholamines were also prominent. This seeming paradox—the fact that levels of dopamine metabolites can be lower in schizophrenic patients than in normal subjects but still positively correlate with symptom severity—is a key impetus to reformulating the complex role of dopamine in schizophrenia.

Is There Hyperdopaminergia in Schizophrenia?

Although the original basis for the hypothesis that dopamine activity is higher than normal in schizophrenia appears questionable, recent evidence, particularly that derived from intracellular recording studies in animals and plasma HVA studies in humans, suggests that neuroleptics act by reducing dopamine activity in mesolimbic dopamine neurons. Moreover, most post-mortem studies have shown higher than normal dopamine and HVA concentrations in various subcortical brain regions and greater than normal dopamine receptor density in the brains of schizophrenic patients (which is probably not a medication effect), although in vivo D_2 receptor binding studies have provided more conflicting results. Still, direct comparisons of CSF, plasma, and urine HVA concentrations in schizophrenic patients and normal subjects do not support hyperdopaminergia and may suggest the opposite, that some brain regions could be hypodopaminergic. These apparent discrepancies may be partially explained by findings on the role of dopamine in the frontal cortex.

HYPODOPAMINERGIA AND FRONTAL LOBE DYSFUNCTION

There are data indicating that frontal lobe dysfunction may be associated with psychotic symptoms. Evidence of frontal lobe damage leading to abnormal behaviors strikingly similar to some of the more persistent symptoms observed in schizophrenia can be found in anecdotal and case series describing patients with frontal lobe injuries and primates with frontal lobe ablations (e.g., 87, 88). Although there is great interindividual variation in the severity and constancy of the symptoms that emerge in patients even with severely damaged frontal lobes, some of these symptoms bear a remarkable resemblance to the deficit state symptoms in schizophrenia. For example, orbitofrontal and anteromedial lesions often produce flattened affect.

Deficit state symptoms are thought to be enduring signs of schizophrenia and include apathy and avolition (8). Bleuler proposed that deficit state symptoms are pathognomonic signs of schizophrenia and are at the root of the poor social and work functions that characterize people with the chronic schizophrenic syndrome. Indeed, several observations from primates suggest that insufficient frontal cortical functioning is responsible for poor social skills. Monkeys with frontal lobe ablations have not only an inability to suppress irrelevant stimuli, poor concentration, and impaired delayed response, but poor social function that is reminiscent of the deficit state symptoms which characterize schizophrenia. These monkeys have been observed to die isolated and alone after being chased from their groups by other animals (89). Also, like the symptoms of schizophrenia, which seem to emerge most prominently during adolescence, the emotional difficulties of monkeys with frontal lobe ablations appear not in infancy, but after the age of 24 months, the monkey equivalent of adolescence (90, 91). Indeed, any hypothesis involving the biological basis of schizophrenia must account for the striking prevalence of onset in late adolescence.

Frontal lobe dysfunction in schizophrenia, specifically hypofrontality, is demonstrable with measurements of cerebral blood flow (92–94). While performing the Wisconsin Card Sorting Test (95), a cognitive task linked to frontal lobe function, schizophrenic patients showed less increase in cerebral blood flow than normal subjects (96). Facility at the Wisconsin Card Sorting Test has been associated with the dorsolateral function of the frontal lobe (97, 98), and it is thought to represent the human test equivalent of the delayed response task used extensively with nonhuman primates as one of the most sensitive measures of frontally mediated cognitive function.

Of great interest is whether cortical hypofrontality could be reflected in dopamine metabolites emerging from (meso)cortical dopamine neurons. Because the mesocortical dopamine tract is relatively devoid of inhibitory autoreceptors, dopamine turnover in these neurons is far greater than in the mesolimbic neurons (99). Given the large volume and greater venous drainage of cortex than of striatum in human brain, the brain contribution to the pool of plasma and CSF HVA is likely to, at least partially, reflect frontal cortex dopamine activity. In fact, only frontal cortical concentrations of HVA significantly correlate with CSF concentrations of HVA in monkeys (100). Thus, CSF and plasma HVA must, in part, reflect mesocortical dopamine activity.

The contribution to CSF HVA of the mesocortical dopamine tract would be expected to be smaller in schizophrenic patients with cortical hypodopaminergia than in normal subjects. This hypothesis is supported by the finding that CSF HVA is lower in (some) schizophrenic patients, particularly those who respond poorly to neuroleptics, than in comparison groups (see 15). Furthermore, low prefrontal dopamine activity in schizophrenic patients could also explain the consistent finding of a negative correlation between CSF HVA and ventricle-brain ratio (101–103) and, more specifically, a negative correlation between prefrontal brain atrophy and CSF HVA (104). That cortical hypofunction is associated with low cortical dopamine activity is suggested by the finding that lack of increase in blood flow during prefrontal tasks in schizophrenic patients is strongly correlated with low CSF HVA concentrations (105). Moreover, blood flow in the prefrontal cortex increases in schizophrenic patients after administration of the dopamine agonists amphetamine (106) and apomorphine (107), suggesting that the hypofrontality found in schizophrenic patients can be redressed by increasing dopamine activity in the prefrontal cortex. The increase in prefrontal blood flow after amphetamine administration correlated significantly with improved performance on the Wisconsin Card Sorting Test (106), strongly suggesting that increasing dopamine activity improves cognition related to prefrontal cortical activity.

Further evidence that dopamine function may be abnormally low in (some) schizophrenic patients comes from studies examining dopamine metabolites in these patients. In addition, plasma HVA has been studied in chronically institutionalized schizophrenic patients with relatively low levels of positive symptoms and prominent deficit symptoms (74). These patients had significantly lower levels of plasma HVA than the age-, gender-, and weight-matched comparison group. This finding corroborates the low concentrations of HVA in the urine of chronic schizophrenic patients (86).

Finally, indirect evidence that dopamine activity is low in (some) schizophrenic patients is suggested by clinical similarities between schizophrenic patients and those with Parkinson's disease. The cognitive and motivational defects in patients with Parkinson's disease are strikingly similar to the deficit symptoms in schizophrenic patients. It has been suggested that these Parkinson's disease symptoms result from low cortical dopamine activity (108), and they diminish after treatment with dopamine agonists (109). Deficit schizophrenic symptoms may also improve after administration of dopamine agonists (110, 111).

Hence, the abnormally low prefrontal activity commonly revealed in schizophrenic patients may be related to the negative/deficit symptom complex and is associated with insufficient activity of mesocortical dopamine neurons.

A MODIFIED DOPAMINE HYPOTHESIS OF SCHIZOPHRENIA

Linking Hypo- and Hyperdopaminergia

The data reviewed so far suggest that schizophrenia can be characterized by hypodopaminergia in mesocortical and hyperdopaminergia in mesolimbic dopamine neurons in at least some patients. There are data indicating that the two conditions, cortical hypodopaminergia and subcortical hyperdopaminergia, may be related.

Lesions of dopamine neurons in the prefrontal cortex of rats, induced with the neurotoxin 6-hydroxydopamine, have resulted in increased levels of dopamine, HVA, and dihydroxyphenylacetic acid (DOPAC) in the striatum (112, 113) and accumbens (112–114) in most but not all (115) studies. These

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lesions also resulted in an increase in D_2 receptor binding sites (112, 113, 116) in the accumbens. Moreover, lesions in the prefrontal cortex augment the responsiveness of the striatal dopamine system to amphetamine (as expressed by increased locomotor activity and circling behavior) (112) and to apomorphine (as expressed by enhanced stereotyped behavior) (117). Conversely, injection of the dopamine agonist apomorphine in the prefrontal cortex of rats reduced the levels of the dopamine metabolites HVA and DOPAC by about 20% in the striatum, suggesting that increasing prefrontal cortical dopamine activity decreases striatal dopamine turnover (117). When the cortical lesion includes noradrenergic pathways, an effect on subcortical dopamine is not found (115), pointing out the important modulatory and permissive role norepinephrine plays in the reciprocal interaction between mesocortical dopaminergic and subcortical dopaminergic activity. However, these findings have not been consistently replicated. In one study (117), surgical ablation of the prefrontal cortex did not result in an increase in striatal dopamine or DOPAC, and the behavioral response to apomorphine was not confirmed when stereotactic injections of ibotenic acid were used to destroy prefrontal dopamine fibers (118). The methods used to destroy prefrontal cortical dopamine fibers in these two studies differed significantly from those using hydroxydopamine plus desipramine and may explain these discrepant results.

Post-stroke patients provided the first evidence that low frontal cortical activity is associated with greater subcortical dopamine activity in humans. Rodents with unilaterally high levels of striatal dopamine turn away from the side with more dopamine ("contraversive turning behavior"). Thus, if cortical lesions increase striatal dopamine, unilateral cortical lesions should unilaterally increase dopamine in the striatum and thus lead to contraversive turning behavior. Indeed, 23 patients with unilateral ischemic frontal cortical lesions (119) showed more contraversive turning behavior than normal subjects. Inasmuch as contraversive turning behavior is due to asymmetrically increased striatal dopamine activity, these data suggest that cortical lesions increase striatal dopamine activity.

Thus, there are circumstances under which low prefrontal dopamine activity may lead to greater than normal subcortical dopamine turnover and D_2 receptor sensitivity. This relationship has obvious implications for a conceptualization of the role of dopamine in schizophrenia, as the data previously reviewed indicate that schizophrenia may be characterized by abnormally low tonic activity of ascending dopamine neurons to the cortex and subsequent high activity in the subcortical dopamine nuclei. This hypothesis is particularly appealing since it would explain the (concurrent) presence of negative and positive symptoms in schizophrenic patients and the finding of both low plasma HVA levels and a positive correlation between severity of psychosis and plasma HVA levels in schizophrenic patients (74). Deficit state symptoms can be related to low prefrontal dopamine activity, low plasma HVA, low CSF HVA, and low prefrontal blood flow during frontal tasks; positive symptoms are related to high dopamine activity in A10, a direct correlation between plasma HVA and positive symptoms, and an association between higher plasma HVA concentration and responsiveness to neuroleptics.

Unanswered Questions

This review and reconceptualization of the role of dopamine in schizophrenia has repeatedly stressed that dopaminergic transmission correlates with the symptoms of the disease. In contrast, dopaminergic mechanisms have not been linked with either pathogenesis or etiology. In fact, there is compelling evidence that hyperdopaminergic transmission is unlikely to be the primary or sole event in either the etiology or pathogenesis of schizophrenia. Rather, modulation of symptoms by dopamine is more consonant with the effects of neuroleptics and the inability of enhanced dopaminergic activity to induce psychosis in normal subjects. Hence, the primary abnormality or abnormalities that make the symptoms of schizophrenia amenable to manipulation by dopaminergic neurotransmission remain undetermined.

It is possible that cortical hypodopaminergia changes a schizophrenic patient's brain in a manner that makes it vulnerable to the psychotomimetic effects of direct or indirect dopamine agonists. However, this speculation remains to be tested, and other possibilities must ultimately be considered. For example, a low concentration of 5-HT_2 receptors in the frontal cortex (120) or a dysplasia of glutamate afferents to frontal cortex (121) may be a critical abnormality that establishes the substrate necessary for sensitivity to dopaminergic manipulations.

Yet another unanswered question is the relationship between morphometric abnormalities in schizophrenia and dopaminergic neurotransmission. A consistent inverse relationship between ventricle size and CSF HVA level has been found (101–103), but more precision in linking abnormalities in brain morphology, cytology, and dopaminergic mechanisms is needed. Increasing attention will inevitably be given to hippocampal and other medial and anterior temporal lobe structures and dopaminergic innervation. Fortunately, advances in immunohistochemistry, quantitative morphology, and molecular biology make possible the simultaneous elucidation of structure and neurochemistry. The availability of adequate human tissue may be the largest obstacle to this work.

Experiments with animals (112–118) have focused on the effect of cortical manipulations on subcortical dopamine neurotransmission. They have established that in some cases subcortical dopaminergic variables can be influenced by changes in cortical dopamine concentrations. Left unaddressed is whether mesolimbic alterations can produce cortical hypodopaminergia. The answer to this question is central to elucidating the sequence of changes in dopaminergic neurotransmission during the elaboration of schizophrenic illness. The temporal sequence has implications for whether deficit state symptoms are always a part of the premorbid state of schizophrenia or whether the first appearance of deficit state symptoms can coincide with or occur after the initial psychotic event.

Finally, an elaboration of the neurochemistry of the symptoms of schizophrenia must deal with the relationship between age and symptom onset. The onset of schizophrenia is exquisitely age dependent. As has been pointed out (122), late adolescence is a time of active modification of cortical organization and changes in dopamine concentrations. The relationship between such changes and the possible development of cortical hypodopaminergia needs to be determined. Late life is another period in which the incidence of psychosis increases. This may be related to the decrease in dopamine activity in the prefrontal cortex found with increasing age (123). Thus, late-life psychoses may also prove a fertile area in which to elucidate the role of dopamine in psychotic symptoms.

IMPLICATIONS

Treatment

It has been commonly noted that the premorbid state of schizophrenic patients is characterized by social withdrawal, isolation, and many other deficit state symptoms, although they are not as pronounced as they are after the schizophrenic illness has begun. As noted, this premorbid condition is consistent with hypodopaminergia in the cortex and raises the question of whether hypodopaminergia is an early dysfunction in schizophrenia and a harbinger of the hyperdopaminergia to follow. If true, might this stage be amenable to intervention with dopamine agonists? Since mesocortical dopamine neurons are primarily of the D_1 type, one would expect selective D_1 or D_5 agonists to be particularly helpful at this stage. Would the administration of D_1 or D_5 agonists to offspring of schizophrenic patients who display negative symptoms prevent the subsequent development of psychosis? Moreover, consistent with the finding by Jaskiw et al. (124) that increasing prefrontal cortical dopamine activity reduces striatal dopamine activity, D_1 or D_5 agonists would be expected to decrease the hypothesized excessive dopamine activity in subcortical dopamine neurons and thus be useful (in combination with traditional D_2 antagonists) in the treatment of acute psychoses as well. Preliminary data on nonresponsive patients treated in this manner are consistent with this notion (125).

Symptoms of schizophrenia can routinely be exacerbated by the administration of drugs that enhance dopamine activity (4–7). All these agents increase dopamine neurotransmission at multiple subtypes of dopamine receptors, but is activation of all subtypes necessary? It can be argued that whereas D_2, D_3, or D_4 stimulation at mesolimbic sites would be psychotomimetic for schizophrenic patients, D_1 or D_5 stimulation may not have the same effect. The determination of the ability, or inability, of D_1 or D_5 agonists to exacerbate schizophrenic symptoms is of great theoretical interest.

Schizophrenia Spectrum Disorder

Although a premorbid schizoid state can precede a schizophrenic episode, the schizoid personality disorder can be persistent and unassociated with the development of psychosis. Nonetheless this "schizophrenia spectrum disorder" is genetically related to schizophrenia (126, 127). If schizoid individuals share with schizophrenic patients the negative symptom of asociality, it seems logical to wonder if D_1 or D_5 agonists might be an effective treatment for the schizoid personality; they might enhance sociality. Thus, a clinical trial of a D_1 or D_5 agonist offers a test of one aspect of this reconceptualized role of dopamine in schizophrenia.

Differences in the relative presence of the positive and negative symptoms of schizophrenia among the full range of schizophrenia spectrum disorders also have key implications for this reconceptualization and are a fertile area of inquiry. There may be dramatic differences in overt symptoms of psychosis between patients with schizoid or schizotypal personality disorders and patients with schizophreniform episodes or schizophrenia. In contrast, negative symptoms, such as asociality and anhedonia, are shared by patients in the schizophrenia spectrum who may differ substantially in terms of positive symptoms. This observation raises the question of whether all individuals with cortical hypodopaminergia inevitably develop subcortical hyperdopaminergia and psychosis. Differences in the reciprocal relationship between cortical and subcortical dopamine may be the reason few patients with schizoid personality become psychotic, in contrast to schizophrenic patients, who may still manifest schizoid function when in remission or residual states. Elucidating these differences could offer new strategies for developing antipsychotic drugs. Hence, comparative investigations of schizophrenia and the spectrum disorders seem valuable. Indeed, such studies might have as their goal the elucidation of the biological and environmental factors that mediate subcortical hyperdopaminergia after cortical hypodopaminergia.

Future Research

The cloning of the D_2 receptor in rodents (45) and humans (48) and the eventual cloning of the D_1 receptor will facilitate the further elaboration of the role of dopamine in schizophrenia. There are at least two D_2 isotypes. Possible differences in the neuroanatomical distribution and function between these different D_2 receptors, as well as among the likely subtypes of the D_1 receptor, need to be elucidated. Already there are suggestions that the protein sequences of D_2 subtypes differ in the region binding G proteins (50). The possibility that D_5 receptors have a greater affinity for dopamine than D_1 receptors makes the D_5 receptor a particularly intriguing target for strategies designed to reverse cortical hypodopaminergia. Similarly, the cloning of D_3, D_4, and D_5 and the elucidation of the biology associated with them may contribute to the understanding of the reciprocal relationship between mesocortical and mesolimbic dopaminergic activity. It might even prove possible to identify the dopamine receptors most critical to the antipsychotic action of neuroleptics and to devise drugs that are far more specific, and have fewer adverse effects, than those presently available. Such a possibility is already suggested by the affinity of clozapine for D_4 receptors.

Regional differences in dopamine activity profoundly affect strategies for measuring dopamine function in schizophrenic patients. Whether dopamine activity is greater or less than that in normal subjects depends on a host of factors, including the relative contribution of the different dopamine tracts to the dopamine variable being measured in any particular patient. CSF and plasma dopamine metabolites and neuroendocrine measures linked to dopamine activity provide different windows onto dopamine systems. They should not be regarded as equivalent. Furthermore, the profile of a patient's symptoms also influences net measures of dopamine activity. Hence, not all schizophrenic patients show the same differences in dopamine activity compared to comparison groups. For example, older schizophrenic patients, who have fewer positive symptoms and relatively more profound deficit states, would be expected to have a very different pattern of dopamine measurements than younger schizophrenic patients, who have prominent positive symptoms. There is in fact evidence for a 2.2% decrease in D_2 receptor density per decade after the age of 20 (128). Moreover, dopamine synthesis diminishes with age (because of decreased tyrosine hydroxylase activity) in humans (for review, see 129). Past contradictory findings must be interpreted with these considerations in mind. Hence, studies of dopamine function in schizophrenia will have to deal with far more variables than have ever been previously considered, including symptoms and the brain regions contributing to the dopaminergic variable being measured.

Finally, it would be surprising if neurotransmitter systems other than dopamine were not involved in the pathogenesis of schizophrenia. There is, for instance, considerable evidence that noradrenergic abnormalities are present in schizophrenia (for review, see 130). A role for serotonergic abnormalities in schizophrenia has been suggested as well (see 131). As previously noted, it is difficult to induce most of the positive symptoms of schizophrenia in nonschizophrenic individuals through the administration of dopaminergic enhancers. In contrast, schizophrenic patients routinely experience exacerbations of symptoms when they receive either direct or indirect dopamine agonists. Thus, neurotransmitter or neuromodulatory abnormalities that are extradopaminergic must be invoked to explain the fundamental difference between schizophrenic and nonpsychotic individuals and to account for the sensitivity of schizophrenic patients to manipulation of dopaminergic neurotransmission.

Nevertheless, the evidence that abnormalities in the dopamine systems affect the modulation of the symptoms of schizophrenia is compelling. Many aspects of the reconceptualization of the role of dopamine in schizophrenia are testable. We hope these ideas will renew interest in the relationship between dopamine and schizophrenia and stimulate investigation of many of the concepts that arise from this reconceptualization. Undoubtedly, many of these notions will prove overly simplistic, but the gathering of more data will, by further reformulations, inevitably bring us closer to an understanding of the pathophysiology of schizophrenia.

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Psychosocial family intervention in schizophrenia: a review of empirical studies

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SYNOPSIS This paper reviews the recent empirical studies on psychosocial family intervention in schizophrenia. Six family educational intervention studies and five more intensive family work studies with 2-year follow-up have been included. A series of questions is asked relating to the effects of such interventions, the efficacy of the different educational models, the active ingredients of these multi-component treatment packages, and the contribution of this new generation of studies to our understanding of the mechanisms through which these interventions work. Suggestions for further research are made. Finally, from the published manuals, the common components of these diverse, multi-component treatment packages of different family-intervention studies are identified.

INTRODUCTION

The past decade has witnessed a proliferation of studies of psychosocial intervention with families in which a member suffers from schizophrenia. The impetus has been partly fuelled by the findings that 30 to 40% of schizophrenic patients relapsed on medication (Leff & Wing, 1971; Johnson, 1976) and partly because of the success of the Expressed Emotion (EE) measure in predicting relapse in schizophrenic patients (Brown *et al.* 1972; Leff & Vaughn, 1985). It is hoped that, if the stressful family atmosphere can be modified, patients will have fewer relapses.

The psychosocial family interventions reviewed in this paper have certain principles in common. First, it is assumed that it is useful to regard schizophrenia as an illness. Secondly, the family is no longer implicated in the aetiology of the illness. Instead the burden borne by the family in caring for a deeply disturbed or impaired individual is acknowledged. Support is provided and the relatives are enlisted as therapeutic agents. Thirdly, the psychosocial interventions offered are part of a treatment package in conjunction with routine drug treatment and out-patient clinical management. The aims of the interventions are broadly the prevention of relapse (secondary prevention) and improvement in the patient's level of functioning. The aim of the paper is to review the short-term and long-term effectiveness of the different intervention studies. Better designed studies with longer follow-ups have been published since the review articles by Barrowclough & Tarrier (1984) and Strachan (1986). These have varied from a short course of education to more intensive family work. In this article, the intervention studies of family education are reviewed first, followed by more intensive studies of family treatment. A series of questions is asked relating to the effectiveness of such intervention packages, the contribution of the new generation of studies to our understanding of the mechanism through which the interventions work, the efficacy of the different methods of family education, and the active ingredients of these multi-component treatment packages. Some broad psychological theories that might inform us on how these interventions work are discussed and suggestions for future research are made. Finally, the published treatment descriptions and manuals are used to identify the common components of the diverse, multi-component intervention packages of different family work studies.

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FAMILY EDUCATION

Barter (1984) defined psycho-education as 'the use of educational techniques, methods and approaches to aid in the recovery from the disabling effects of mental illness or as an adjunct to the treatment of the mentally ill, usually within the framework of another ongoing treatment approach or as part of a research programme'. This definition broadly applies to the family education studies reviewed in this article. The popularity of education for families of the mentally ill is due to the gradual realization by professionals that the primary burden and responsibility for care of a mentally ill person lies essentially in the family (Katschnig & Konieczna, 1989). This is particularly true in countries where the emphasis on the care of the mentally ill is in the community. In the case of schizophrenia, the popularity is also due to the influential research finding regarding EE. Brown *et al.* (1972) speculated quite early on that high EE is due to a relative's lack of knowledge about the illness. Leff & Vaughn (1985) suggested that high EE relatives tended to believe patients had control over their symptoms, whereas low EE relatives believed that patients were genuinely ill and had very little control over their disturbed behaviour. By helping relatives to understand that patients had a genuine illness and very limited control over their symptoms, it is hoped that better understanding on the part of the relatives would attenuate their critical behaviour.

EDUCATION STUDIES

Table 1 summarizes the contents of the education packages, the method by which the education was delivered and the number of education sessions of the various studies. Six studies of schizophrenia family education are included in this section. The education packages in the studies reviewed are of short duration ranging from 1 session to 6 sessions in a single family or multi-family group. The studies by McGill *et al.* (1983), Berkowitz *et al.* (1984) and Barrowclough *et al.* (1987) are part of more intensive family interventions. They are included here for the purpose of comparison. Furthermore, the study by Abramowitz & Coursey (1989) devoted one session to teaching explicitly some psychological techniques of coping, using a problem-solving approach (Beck, 1976) and cognitive rehearsal (Beck *et al.* 1979). However, it is subsumed under family education, as the main purpose of 6-session intervention was to offer education and support to the carers with little focus on family therapeutic issues.

Discussion

1. *What are the effects of family education?*

A direct comparison of the effects of the educational intervention studies is impossible because no two studies used the same design. The studies also differ in the content of the educational package. The time of post-intervention assessment varied from immediately (McGill *et al.* 1983; Berkowitz *et al.* 1984; Smith & Birchwood, 1987; Abramowitz & Coursey, 1989), to one-week (Barrowclough *et al.* 1987), 2-month (Cozolino *et al.* 1988), 6-month (Smith & Birchwood, 1987) or up to 9-month follow-up (McGill *et al.* 1983; Berkowitz *et al.* 1984). Furthermore, the findings of the 9-month follow-up of McGill *et al.* and Berkowitz *et al.* cannot be attributed to the initial education packages alone as their families received ongoing family work in the intervening 9 months. However, the studies taken as a whole do suggest the following.

A. Gain in knowledge A gain in knowledge has been reported in all the studies reviewed here with the exception of Cozolino *et al.*'s study which consisted of only one educational session. Berkowitz *et al.* (1984) reported that at immediate post-intervention, more relatives in the experimental group who received education knew about the diagnosis. However, there was no significant difference between their experimental group and their control group who did not receive education in terms of their knowledge of symptomatology. At the 9-month follow-up, more relatives in the experimental group knew about the diagnosis and the symptoms. Barrowclough *et al.* (1987) reported that a post-intervention assessment at an interval of one week showed relatives had an increase in their scores and a significant change from the negative or neutral answers to positive answers in the 'Knowledge About Schizophrenia Interview', except in the section on medication. There was no significant difference in the change scores

Table 1. *The number of sessions, content of the package and method of delivery of the various educational programmes*

Author	No. of sessions	Content	Method of delivery
McGill *et al.* (1983)	Two sessions	Nature of schizophrenia, symptomatology, role of environmental stress and drugs, and side effects	1. Didactic with patient present as expert 2. Single family
Berkowitz *et al.* (1984)	Two sessions	Diagnosis, symptomatology, aetiology, course and outcome, and management	1. Didactic with patient absent 2. Single family
Barrowclough *et al.* (1987)	Two sessions	Diagnosis, symptomatology, aetiology, medication, course and outcome and management	1. Interactive with patient and relatives brought together at the end of second session 2. Single family
Smith & Birchwood (1987)	Four weekly sessions	Concepts of schizophrenia, cause and epidemiology, symptomatology, treatment and outcome, and hospital and community resources	1. Oral presentation with audio-visual aids, booklets and homework assignment *v.* booklet through the post and homework assignment 2. Multi-family in the oral presentation condition
Cozolino *et al.* (1988)	One 3 h session	Diagnosis, symptomatology, aetiology, course and outcome, medication, management, and alternative treatment	1. Didactic with patient absent 2. Multi-family sessions
Abramowitz & Coursey (1989)	Six 2 h sessions every 2 weeks	Understanding of illness, medication, appropriate expectation, management, community resources and advocacy groups, problem-solving approach, developing family network and support	1. Didactic with patient absent 2. Encourage sharing of experience, solution, support and encouragement 3. Multi-family seminars

between the more or less critical relatives suggesting that the critical relatives were equally capable of change. Furthermore, there was a near-significant finding that the relatives of the more recent onset patients showed a greater change score, suggesting those relatives were more amenable to the educational approach. However, similar to Berkowitz *et al.*'s findings, a significant proportion of relatives in Barrowclough *et al.*'s study showed very little gain in knowledge of the aetiology of schizophrenia. Smith & Birchwood's (1987) showed that the relatives in both postal- and group-education groups had significantly increased scores on the Knowledge Questionnaire immediately after receiving education and at the 6-month follow-up compared to the baseline.

B. Change in belief systems The evidence to date suggests that education on its own has a very limited impact on the relatives' belief systems. Berkowitz *et al.* (1984) reported that at post intervention more high EE relatives in the experimental group were optimistic than in the control group about the patient's future; and more high EE relatives in the experimental group saw the patient as an individual. Smith & Birchwood (1987) found that the education package did not affect the relatives' belief system: such as the family's beliefs and expectations about their role in treatment; the effectiveness of medical treatment, the patient's control over the symptoms; and the family's worry about the individual and his behaviour. The only significant finding in terms of the relatives' beliefs was a significant increase in optimism concerning the family's role in treatment in the group-education condition. Unfortunately this effect was not maintained at the 6-month follow-up. Cozolino *et al.* (1988) also found their education package had no effect on the attitudes of the relatives in terms of being hostile or critical, how bothersome these symptoms were, controllability of the symptoms, and symptom stability over time. While high EE relatives did show significantly more critical attribution at pre-intervention and some reduction of negative attribution after family education, they remained more negative towards the patients than low EE relatives. Cozolino *et al.* also reported that their intervention had no significant effect on the understandability of the illness. However, there was a non-significant tendency that education may have an impact on the relatives' self-blame (the control group blamed themselves more, while the experimental group blamed themselves less). Similarly, Abramowitz & Coursey (1989) reported that there was no significant effect on the negative feelings towards the patient or subjective self-efficacy.

C. Effect on the relatives' distress and burden

The earlier studies by McGill *et al.* (1983), Berkowitz *et al.* (1984) and Barrowclough *et al.* (1987) were influenced by the thinking that high EE in relatives might be caused by a lack of knowledge. Hence gains in knowledge were the logical outcome measure. No direct assessment was made of the effect of education on the relatives' fears and worries, anxieties, distress and burden, and the relatives' subjective feelings of support. The second generation of education studies included here all represented an attempt to evaluate the impact of the educational package on the relatives' reported distress and burden. Smith & Birchwood (1987) reported that there was a non-specific effect of reduction in reported burden at the 6-month follow-up in both the group- and postal-education conditions as measured by the 22-item Family Distress Scale (Pasamanick *et al.* 1967). The reported gain in relatives' optimism in the group condition and the significant gain in the relatives' distress, as measured by the relative's Symptom Rating Test (Kellner & Sheffield, 1973), in both conditions at post-intervention had disappeared at the 6-month follow-up. Likewise, Cozolino *et al.* (1989) reported that high EE relatives in the experimental group felt more supported than the high EE relatives in the control group. However, there was no significant difference in the subjective feeling of support between the low EE relatives in the two groups. Abramowitz & Coursey (1989) used a variety of measures at immediate post-intervention. These included State and Trait Anxiety (Speilberger *et al.* 1970); Relative Distress Scale (Greene, 1982) with three subscales of personal distress, negative feelings towards the patient and disruption of family life; and Generalized Self-Efficacy Scale (Tipton & Worthington, 1984). Results showed significantly less trait anxiety, less personal distress and family disruption in the experimental groups at post intervention. Unfortunately, no longer-term follow-up has been done. To sum up, some positive findings at post-intervention have been reported by both Smith & Birchwood (1987) and Abrambowitz & Coursey (1989). However, the long-term effect is dubious or unknown.

D. Change in behaviour and relapse rate

Cozolino *et al.* (1988) reported that their education package had no effect on the frequency of argument as measured in the 12 typical situations in the Family Conflict Scale (Liberman *et al.*, unpublished document) and the number of hours of contact per week. The longer-term effectiveness of the education packages at 9 months of the two earlier studies by McGill *et al.* (1983) and Berkowitz *et al.* (1984) are difficult to evaluate as the education is part of an ongoing intervention study. However Tarrier *et al.* (1988) reported the high EE education-only control group had a relapse rate of 43% compared to 53% of the high EE control group at nine months, and 53% and 60% respectively at two years. Similarly, the low EE education only control group had a relapse rate of 22% compared to 20% in the routine management low EE group at 9 months. These results indicated that education alone was not effective in preventing relapse in this population.

2. *What is the best model of family education?*

Tarrier & Barrowclough (1986) suggested that an interactive model of education which take into account the person's lay model of the illness with the content tailored towards the individual family would be a more effective way to educate the relatives. Their didactic educational sessions were more interactive, taking the relatives' lay model of schizophrenia seriously and emphasizing the areas in which the relatives were ignorant. Whether the interactive model of education is more effective is difficult to assess as Barrowclough *et al.*'s instrument of functional values of knowledge was not used in any other study. However, both Berkowitz *et al.* (1984) and Barrowclough *et al.* (1987) commented on how little the relatives had learned about aetiology, indicating that the relatives clung on to their own concept of what caused the patient to be 'ill' rather firmly whether an interactive mode or the more traditional mode of education was used.

Smith & Birchwood's (1987) study was the only one that attempted to evaluate the different methods by which family education was carried out. Relatives were randomly allocated into a group-education condition or a postal-education condition. The group-education was carried out in 4 weekly semi-structured seminars in a multi-family setting with audio-visual aids. Discussion was encouraged and homework was given. The postal-condition consisted of the printed material with homework sent through the post. The result demonstrated that at post-intervention there was a gain in optimism concerning the relatives' role in treatment in the group-education condition, which was not maintained at the 6-month follow-up. The significant reductions on the relatives' distress and reduction in reported burden as well as a gain in knowledge occurred in both the group- and the postal-education conditions. However, the relatives in the group condition learnt more about schizophrenia than those in the postal condition, even though all relatives in both conditions showed evidence of a gain in knowledge. Hence, the results did not support the superiority of either of the two methods of information delivery, except that relatives in the group-education condition learnt significantly more than those in the postal-education condition.

In all the studies reviewed here, the patient is normally absent from the family education sessions so that the relatives could ask questions without any inhibitions. The exception is McGill *et al.*'s (1983) study in which the patient was included in the education sessions as an expert who had some first-hand experience of the illness. In Barrowclough *et al.*'s study, the relatives were educated alone. However, the patient went through the same educational procedure separately if their mental state allowed it and the relatives and patient were brought together at the end of the second session for further discussions. Unfortunately there are no direct data to support the superiority of either of these two practices.

Lastly, the timing of offering family education needs to be explored. Smith & Birchwood (1987), and Abramowitz & Coursey (1989), offered education to families when the patients did not necessarily have an acute exacerbation of their illness. The other four studies offered education to families after a recent acute episode, and in some cases the patients were still hospitalized. The relative effectiveness of these two practices is not known as no direct comparison between these studies is possible. However it does appear from the studies by McGill *et al.* (1983), Berkowitz *et al.* (1984), and Barrowclough *et al.* (1987) that the families could absorb information when the patients were unwell. Furthermore, engaging the families when the patients were in remission could be a problem. Smith & Birchwood (1987) reported that 39·5% of families approached for the study either refused to take part in the study or dropped out prior to the start of the study. Similarly, Abramowitz & Coursey (1989) reported 37% of their families who were initially circulated about the education programme showed no response. Hence, the education process should start at a crisis point when information is most needed.

To sum up, there is no evidence to support whether education could be more effective when carried out in an interactive mode, with the patients included in the sessions, or when the family has experienced a recent crisis. However, there is some evidence that relatives learn more in a face-to-face semi-structured seminar and showed more optimism concerning their role in treatment in the short term than through written material. There is also some evidence that it is easier to engage the family when they have experienced a recent crisis.

Conclusion

As a whole, the studies reviewed did not show any substantial beneficial effect of brief educational packages, other than a gain in knowledge. There is also some evidence that the relatives' burden and distress were alleviated to some extent. However, the most encouraging findings were reported by Abramowitz & Coursey (1989) which represented an attempt to provide a short-term intervention with a mix of educational and problem-solving approaches. At post-intervention, the package appeared to be promising. However, the longer-term effectiveness of the intervention is unknown.

Berkowitz *et al.* (1984) concluded that family education was a good form of family engagement because it was relatively non-threatening and provided a good grounding for further therapeutic work. They also suggested that some imparting of knowledge is important for the non-specific effect of the process. Relatives might not remember enough of the details of the aetiology to score. However, the process might reduce guilt and enhance the feeling of being supported. Smith & Birchwood also reported no correlation between knowledge gain and attitudinal change, stress and burden in the relatives. They argued that the relatives' subjective feelings of being more knowledgeable could lead to improvement in their cognitive mastery and hence reduce their feelings of uncertainty, helplessness and hopelessness. MacCarthy (1988) argued that educating relatives is also a moral issue. The consumers have the right to be informed and their demand for information is often great. Furthermore, the provision of knowledge is consistent with a psychological model of problem-solving coping (Carver *et al.* 1989) in which knowledge is essential for planning, taking direct action, seeking assistance, screening out other activities and sometimes even forcing oneself to wait.

To sum up, the evidence to date tends to caution against the organization of short education packages without other intervention components. Despite some evidence of short-term gain in reducing distress and burden, families need more input than brief education packages. The studies which included education as part of the larger intervention packages are reviewed next.

FAMILY INTERVENTION IN SCHIZOPHRENIA

The inclusion criteria of the studies in this section were as follows.

(1) The subjects had a diagnosis of schizophrenia based on some standard research tool such as the PSE (Wing *et al.* 1974) or RDC (Spitzer *et al.* 1978).

(2) A design was used in which subjects were randomly allocated to a control/comparison group or an experimental group.

(3) The experimental group received some form of psychosocial family intervention.

(4) An effort was made to control for the effects of drugs.

To date, 5 major family intervention studies in schizophrenia have been published with 2-year outcomes (Leff *et al.* 1982, 1985, 1988, 1990; Falloon *et al.* 1982, 1985, 1987; Hogarty *et al.* 1986, 1987; Tarrier *et al.* 1988, 1989). The earlier studies by Weakland *et al.* (1974), Palazoli *et al.* (1978) and Bowen (1978), were excluded because none of these studies randomly allocated subjects into a control/comparison group. The study by Goldstein *et al.* (1978) was also excluded as its main objective was to assess the effect of a short-term crisis-orientated family therapy on the survival of patients. No outcome beyond that of the 6-month post intervention has been reported for the whole sample, two-thirds of which was suffering from a first episode. Hence it is of uncertain long-term effectiveness and difficult to know whether it would generalize to a more chronic sample. (For a review of these studies, see Strachan, 1986 and Barrowclough & Tarrier, 1984.) Included in this review is the study by Kottgen *et al.* (1984). This is a potentially important study as it adopted a radically different therapeutic approach and had a significantly worse outcome. Unfortunately, in addition to the psychodynamic orientation, this study was different from the other published studies reviewed here in some crucial respects. Vaughn (1986) pointed out three major differences: difference in relapse criteria, possible misclassification of families into the low EE category, and the failure to analyse separately the low EE low-contact group who lived away from home. Because of these differences, a comparison between this study and the other published studies is impossible. However, the study does sound a note of caution about this type of more psychodynamic intervention.

Table 2 summarizes the aims of the six studies, the characteristics of the samples, the selection criteria, and the comparison groups. The five successful family treatment studies reviewed in this section are different from classical family therapy. There is no assumption that the origin of pathological behaviour lies with pathological interactions in the family. Irrespective of the aetiology of schizophrenia, the therapist accepts a disease model that carries implications of the need for retraining, rehabilitation and the avoidance of situations that lead to distress. (See Berkowitz *et al.* 1981 for a more detailed discussion of the implications of disease model and labelling.) The therapist also bears in mind the constraints of the illness in carrying out the intervention. Hence goals are set in small steps in line with the patient's progress in mental functioning. A delicate balance is struck between getting the patient to improve his functioning and over-stimulation leading to stress and ultimately relapse. The studies reviewed here also had some weaknesses, which are perhaps worth mentioning here. For example in Leff *et al.*'s (1982) study, the PSE assessor was not blind to the subject's treatment condition. As the authors pointed out, an increase in the intensity of symptoms is more subjective. An independent assessor was brought in for these cases; and he did not always agree with the original assessor. In Falloon *et al.*'s (1982) study, a weakness in the design was that no process research was carried out into the therapists' competence in carrying out the two types of treatment or the extent to which the therapists adhered to the treatment manuals. Since the same therapists were used in both treatment conditions, they could have had different expectations of the effectiveness of the two treatment conditions. Alternatively, the therapists could have been more or less competent in one or the other mode of treatment, hence affecting outcome. In Tarrier *et al.*'s (1989) study, the patients' relapse at the 2-years follow-up was largely dependent on hospital admissions. Independent assessors blind to the patients's treatment conditions went through the patient's admission notes. If the admission was due to a recurrence or exacerbation of psychotic symptoms, then the patient was classified as having relapsed. Lastly, in Leff *et al.*'s (1988) study, 5 of the 11 families refused to attend any relatives' groups. Even though there was no statistical difference in the relapse rates between the family treatment and relatives' group conditions, the relative effectiveness of the two treatment conditions needs to be replicated for a firm conclusion due to the high attrition rate in the relatives' group and the small number of families in the study.

Discussion

In this section a series of questions related to the effectiveness of the interventions, the mechanisms through which they work, the possible active ingredients and the studies' common ingredients are explored.

1. *What are the effects of the family intervention?*

A. Patients' mental state Other than the controversial study by Kottgen *et al.* (1984), the above studies conducted by different teams and at different geographical locations have demonstrated consistently a robust effect that family intervention is effective in preventing schizophrenic relapse at 9 months or one year. The relapse rates of the family treatment group ranged from 6 to 23%, compared with 40 to 53% in the comparison groups. By 24 months, the effect is less impressive as a fairly high proportion of patients has relapsed in the family treatment group in most studies. This ranged from 17 to 44%, compared with 59 to 83% in the comparison of high EE groups. In fact the relapse rate in most studies was about 40% in the family treatment group. It looks as if the existing intervention packages serve to delay rather than to prevent relapse in the longer term. This is supported by the clinical observation that relapses in patients from low EE families are not grossly under-represented in hospitals. However, with the exception of Falloon *et al.*'s study which showed a favourable outcome of 17% relapse at the 2-year follow-up, the therapeutic contact between the therapeutic team and the patients was minimal or nonexistent after the initial 9 months. For example, in Leff *et al.*'s first study, the medians for both further family sessions and relatives' group were both 1·1. In their second study, only one family attended the group regularly beyond the initial 9 months. Similarly, in Tarrier *et al.*'s study, only one family was seen regularly once every 6 months by the family treatment team. The model used in these interventions was one akin to the acute medical model of cure in which the patient is expected to recover after an intensive course of treatment and rehabilitation. However, these studies were conducted within the limit of research design. With an illness such as schizophrenia, perhaps a model that entails working on a continual basis with families would be more appropriate as recommended by Tarrier *et al.* (1989). A comparatively more flexible and intense form of therapeutic contact between 9 months and 2 years might lead to a better outcome at the end of the period.

In addition to relapse rate, Falloon *et al.* (1982, 1985) reported other outcome measures including Clinical Exacerbation (defined as a recurrence of florid symptoms that lasted at least a week or necessitated a change of medication); Target Symptom Rating done

Table 2. *Characteristics of samples, selection criteria, comparison groups, aims of intervention and outcome of the various studies*

Study	Sample	Selection criteria	Comparison groups	Aims of intervention	9 months/1 year	2 years
Leff *et al.* (1982, 1985)	24 patients randomly allocated to treatment groups mean age: expt. group 39 yr control group 30 yr mean no. of previous admissions: expt. group 2·3 control group 1·7	(1) PSE schizophrenia (2) High EE family (3) High contact (4) Age between 16 and 65 years	(1) Experimental group of psychosocial treatment consisted of family education, family therapy and relatives' group + routine clinical management (2) Control group of routine clinical management	(1) To manipulate EE and investigate the causal relationship between EE and relapse (2) To compare the relative effectiveness of psychosocial intervention with routine out-patient care only	9% in expt. group relapsed. 50% in control group relapsed	40% in expt. group relapsed (including 2 patients who committed suicide) 78% in control group relapsed
Falloon *et al.* (1982, 1985)	36 patients randomly allocated to treatment groups mean age: expt. group 25·0 yr control group 26·2 yr mean no. of previous admissions: expt group 3·1 control group 2·9	(1) PSE schizophrenia (2) High EE families (except 3 families who are included because of high risk according to other criteria) (3) Daily contact with their biological parents (4) Age between 18 and 45 yr	(1) Experimental group of behavioural family treatment (2) Control group of individual treatment	(1) To compare the effectiveness of family treatment with individual supportive treatment in the prevention of relapse	6% in the expt. group relapsed 44% in the control group relapsed	17% in expt. group relapsed 83% in the control group relapsed
Hogarty *et al.* (1986, 1987)	103 patients randomly allocated to treatment groups mean age of whole sample 27 yr (± 7·7) mean no. of previous hospital admissions 2·7 (± 3·1)	(1) RDC schizophrenia or schizo-affective psychosis (2) 1 out of 3 months prior to admission living in a high EE household (not necessarily high contact) (3) Age between 17 and 55 yr	(1) Family treatment (22 pt.) (2) Social skill training (23 pt.) (3) Family treatment and social skill training (23 pt.) (4) Control group of outpatient management (35 pt.)	(1) To reduce the emotional climate of the home (2) To maintain reasonable expectation in the family on patients' performance	23% relapsed in family treatment group 30% relapsed in social skill training group 9% relapsed in the combined group 49% relapsed in control group	34% relapsed in family treatment group 42% relapsed in social skill training group 25% relapsed in the combined group 66·7% relapsed in the control group

Tarrier *et al* (1988, 1989)	83 patients allocated to groups using stratified random allocation taking into account no. of previous episodes and presence of residual symptoms mean age 35·3 yr (± 12·8) mean no. of previous episodes 2·8 (± 3·6)	(1) PSE schizophrenia (2) Lived with relative for 3 months prior to admission and intending to return home on discharge (3) Age between 16 and 64 yr	*Four high EE groups*: (1) Enactive behavioural treatment (16 pts) (2) Symbolic behavioural treatment (16 pts) (3) Education only (16 pts) (4) Routine treatment (16 pts) *Two low EE groups*: (1) Education only (9 pts) (2) Routine treatment (10 pts)	(1) To eliminate components of high EE (2) To maximize the patients' level of functioning	*High EE group relapse rate* 17% in Enactive behaviour group 8% in Symbolic behaviour group 43% in Education only group. 53% in Routine treatment group *Low EE groups relapse rate* 22% in Education only group 20% in Routine treatment group	*Relapse rate* 33% in behaviour treatment group (Enactive + Symbolic) 59% in control high EE group 33% in control low EE group
Kottgen *et al* (1984)	49 patients allocated into groups	(1) PSE schizophrenia (2) Age between 18 and 30 yr	(1) High EE experimental group of relatives' and patients' groups (15 pts) (2) High EE control group of conventional treatment (14 pts) (3) Low EE control group of conventional treatment (20 pts)	(1) To air pent-up feeling and exchange views in the relative's group (2) To aid patients to acquire a peer group (3) To disentangle the emotional knots in high EE families (4) To provide understanding and more detached relationship	33·3% relapsed in high EE expt. group 50·0% relapsed in high EE control group 45·0% relapsed in low EE control group	N.A.
Leff *et al*. (1988, 1990)	24 patients randomly allocated into treatment groups mean age: Family therapy group 26 yr, Relatives group 27 yr mean no. of previous admissions: Family therapy 2·0 Relative group 2·5	(1) PSE schizophrenia (2) High EE household (3) High contact (4) Age between 16 and 65 yr	(1) Education + family therapy (2) Education + relatives group	To compare the effectiveness of relatives group and family therapy	8% in education + family group relapsed 33% in education + relatives' group relapsed	33% in education + family therapy group relapsed 36% in education + relatives' group relapsed

monthly on 2 or 3 florid symptoms rated on a 7-point severity scale by the pharmaco-therapists who were blind to the therapy conditions; and Symptom Remission (defined as no florid symptoms in the previous month according to the PSE). Furthermore, Community Tenure (defined as the number of days the patient spent in a psychiatric hospital and the number of admissions) was calculated. A significant gain in all these measures had been reported in the family treatment group both at 9 months and 2 years. Leff *et al.* (1990) reported an improvement in negative symptoms at their 2-year follow-up among patients treated by family therapy alone and relatives' group alone. Unfortunately, as the authors pointed out, in the absence of a control group, this improvement in negative symptoms cannot be attributed entirely to the psycho-social intervention package.

B. Patients' social functioning Falloon *et al.* (1985, 1987) reported that both the family and individual interventions showed significant interactions with time in the ANCOVA with most social, clinical and family burden measures. However, the between-group difference always favoured the family approach. A survey of clinical records revealed that the family-treated patients had longer periods of employment or rehabilitation programmes at the 9-month follow-up. At 2 years, patients in the family-treated group had an average of 12·6 active months compared to 7·2 months in the control group. In terms of the adjustment of the family unit, the Family Adjustment Scale (SAS-SR, Weissman *et al.* 1978) completed by parents showed an improvement at the 9-month and 2-year follow-ups in both the experimental and control conditions. The self-reported Social Adjustment Scale, SAS-SR (Weissman *et al.* 1978), showed that there was a significantly greater overall social adjustment in the family treated group with a superior adjustment in leisure activities and family relationships at 9 months. Seven items from the Social Behaviour Assessment Scale (SBAS, Platt *et al.* 1980) were examined as an additional source of reporting from relatives. These revealed greater improvements in the patients' performance in household tasks, work or study activities and friendship outside the family in the family treated group at 9 months. At 24 months, the performance of the family treated group was superior in household tasks and decision-making, with leisure activity approaching significance. Hence, the authors concluded that there was an indirect effect in patients' social functioning even though the family treatment consisted of a generic problem-solving approach and not techniques that aimed at social functioning *per se*. Falloon *et al.* also reported that social rehabilitation was difficult for many patients, particularly social activities with friends because of the fear of rejection.

Similarly Barrowclough & Tarrier (1990) reported a significant improvement in the high EE group on the Withdrawal, Interpersonal Functioning and Prosocial Activities subscales as well as the overall score of the Social Adjustment Scale (Birchwood *et al.* 1990) over the 9 months. In the high EE control group, patients showed a significant improvement in the Interpersonal Functioning subscale but a significant deterioration in the Withdrawal subscale. The patients in the low EE control group showed significant improvement in the overall score and a significant improvement on the Interpersonal Functioning and Independence subscales from post-discharge to 9 months. Hence the high EE treatment group had significant improvements in three sub-scales and the overall score at the 9-month follow-up whereas the high EE control group had a significant improvement in one subscale but deterioration in another. Unfortunately, the information on the patients's social functioning was obtained only from the relative who had most contact with the patient. No other source of information (such as the patient's self-report) was used. As 76% of the patients in the study lived with only a single relative and 77% of the patients were from high EE households, a high proportion of the relatives from whom the patients' social performance was rated were initially high EE relatives. Therefore, the level of social functioning reported at baseline in high EE households could simply be due to a bias in reporting by the critical or hostile relatives. As the relatives changed from high to low EE status at the 9-month follow-up, there could be a more objective report of the patient's social performance. Hence the change in the Social Adjustment Scale could be confounded by the reporting relative's attitude as reflected in the EE rating.

C. Relatives' burden and distress Falloon *et al.* (1985, 1987) reported that the family-treated group reported greater interference in family life at the baseline but improved at 9 months according to the SBAS when the individually treated group reported greater family life interference. However, at the 2-year follow-up, *both* groups showed improvement. The most striking improvement was in the individually treated group which was associated with a greater improvement in social functioning. The subjective burden derived from the SBAS was significantly reduced only in the family-treated group at both the 9-month and 2-year follow-ups. The Hopkins Symptom Checklist (Lipman *et al.* 1968) was used for parental symptoms. There were significantly fewer mothers in the family-treated group who complained about somatization and obsessive-compulsive symptoms at both 9-month and 2-year follow-ups. This effect did not apply to the fathers in the study. Hence the effects of the intervention programme were mixed. Tarrier *et al.* (1988) also measured the subjective distress and burden of the relatives. However, to date no report on the stress and burden on the family has been published.

D. Change in family atmosphere One of the major aims of most of the studies is the reduction of adverse family atmosphere. This is reflected by a repeat of some assessment of family climate, most commonly EE assessment. The outcome has been by and large successful. For example, Leff *et al.* (1982, 1988) and Tarrier *et al.* (1988) reported that at the 9-month follow-up, there was a significant reduction in critical comments in the experimental group. Tarrier *et al.* (1988) also found a significant reduction in the emotional over-involvement and warmth in the behavioural groups at 9 months. Similarly Leff *et al.* (1990) found a significant reduction in emotional over-involvement at 2 years. In Hogarty *et al.*'s study, unfortunately 23% in the experimental group and 52% in the control declined a second Camberwell Family Interview (CFI) from which the EE rating was derived. For those who refused, the research team ventured to guess their EE status. The proportion of families changed from high to low EE status at 1-year follow-up were: 17% in the control group, 30% in the social skill training group, 43% in the family-treatment group and 35% in the combined treatment group. However, this finding must be interpreted with caution because of the high proportion of relatives who refused to have a second CFI. Unfortunately in Falloon *et al.*'s (1982, 1985) study, no repeat of EE measure was carried out. However at 9 months, Doane *et al.* (1986), using a direct interactive procedure called Affective Style Measure, reported 88% of the family-treated group had a reduction in criticism or intrusiveness or both, whereas 50% in the control group had an increased score in one or both measures.

2. *How does it work?*

In Hogarty *et al.*'s (1986) study, the best treatment outcome at 9 months in the combined condition consisted of seeing patients once a week and the families bi-weekly for a considerable period of time. Hence this group had far more therapeutic input than any of the other groups in his study. Similarly, in Leff *et al.*'s (1982, 1988), Falloon *et al.*'s (1982) and Tarrier *et al.*'s (1988) studies, the family-treatment groups had proportionately more therapeutic contacts than their comparison groups. The effect of treatment could be due to the non-specific effect of greater therapeutic contacts. As a result, there is greater understanding of the rationale of medical treatment and greater vigilance from the family to ensure its compliance. This postulation is consistent with Falloon *et al.*'s finding that patients in their family-treated condition were better at complying with drugs. In fact Falloon's family treatment included training for the patient and families to recognize early prodromes of relapse and the medication was actively monitored by clinicians. Hogarty *et al.* (1986) commented on the estimated relapse rates amongst controls of 54 to 60% at one year in the studies by Leff *et al.* (1982, 1985) and Falloon *et al.* (1982) were similar to those of placebo groups in other published drug controlled, maintenance studies. He concluded such a high relapse rate might include drug defaulters. However, in the two studies by Leff *et al.* and in the study by Hogarty *et al.* most patients in both the family-treated and comparison groups received depot injections. This rather supported Leff *et al.*'s (1985) argument that the presence of high EE families placed the patients at an increased risk of relapse. In any case, the relapse rates of the treatment groups in Hogarty *et al.*'s study were a significant improvement compared to 49% of relapse in the drug-treatment group. Moreover, Tarrier *et al.*'s systematic monitoring of the patients' medication on a 4-point scale has ruled out the possibility that the effectiveness of their intervention was due to drug compliance. Hence their outcomes did not seem to be due to drugs entirely. Hogarty *et al.* also found that family treatment was effective for both the drug compliant and drug non-compliant subjects. Hence there is some evidence that family treatment is effective, independent of greater drug compliance.

Another possible mechanism for the confounding effect of greater therapeutic contact is better liaison between the therapists and the clinical team so that the clinical team could intervene more promptly or frequently at an earlier stage before a full-blown relapse had set in. This is consistent with the community care of schizophrenia programmes reported by Test (1990) and Hoult *et al.* (1983) who demonstrated some success in maintaining schizophrenic patients in the community by providing direct and close support to the patients and their families. However, Tarrier *et al.*'s study showed that there was no difference in the patients' contact with the clinical team between their family-treated and comparison groups. Falloon *et al.* also demonstrated that the patients in the family-treated group needed less medication. Therefore, it is unlikely that the treatment effect is due to either greater compliance with drugs, more energetic drug treatment or more contact with the clinical team. Moreover, Tarrier (1989) reported there was no significant difference in the number of life events the patients had experienced between the family intervention group and the comparison groups.

Furthermore in the studies reviewed here there is no comparison group where therapists worked with the families in a placebo-treatment way. However, the non-specific effects of simply working with the family are, to some degree, negated by the negative outcome of Kottgen *et al.*'s (1984) study. Even through Kottgen *et al.*'s criteria for relapse were different from other studies reviewed here, the proportions of patients who relapsed were similar across the treatment and control groups. Hence the effectiveness of family treatment may indeed depend on certain therapeutic ingredients rather than simply on regular contacts.

With the exception of Falloon *et al.*'s study, EE served both as a predictor and as an outcome measure which was then related to patients' relapse. Across studies, none of the patients whose family changed from high to low EE relapsed at 9 months. However, there is accumulating evidence that EE can change spontaneously over time. Brown *et al.* (1972) found about 30% of high EE relatives changed from high to low EE spontaneously. Similarly, Tarrier *et al.* (1988) reported a significant change in the high EE control groups over time. In fact, a small proportion of non-critical relatives became critical over time. Since EE is a measure taken initially at a crisis point, it might fluctuate with the patient's mental state. As the patients become more stable, the EE level may come down. The relationship between EE, intervention and relapse is probably quite complex which a unidirectional model would be unable to explain. Furthermore, it does not look as if reducing EE is the only mechanism through which these interventions work. Hogarty *et al.* found that in the combined treatment group, a change from high to low EE was not necessary for good outcome. Leff *et al.* (1982) also found that a reduction in face-to-face contact was effective in preventing relapse in households that did not change to low EE status. This led to Kuipers & Bebbington's (1988) postulation that when the intervention is directly with the patient, good outcome may not necessarily be related to reduction in EE.

Brown *et al.* (1972) and Barrowclough & Tarrier (1990) reported that high EE was related to poorer social functioning in the patients. The intervention studies reviewed here have either directly or indirectly tried to improve the patients' social functioning. Leff's and Hogarty's teams used a structured, behavioural approach explicitly to improve self-care and social functioning. The problem-solving approach used by Falloon's and Tarrier's teams was capable of dealing with these issues if indeed self-care and social functioning were the problems. The evidence to date provided no strong evidence whether increasing the patient's level of social functioning had a protective effect. Hogarty *et al.* (1974) reported a delayed effect of their Major Role Therapy (MRT). There was no significant effect of MRT for the whole 24 months after hospital discharge. However, MRT did reduce relapse rate among those who survived the first 6 months in the community. Hogarty *et al.* (1979) reported that there was a clear trend that long-acting fluphenazine decanoate and social therapy reduced the risk of relapse when the whole period of 24 months was taken into account. However, the result was not significant as their sample of 105 did not have enough statistical power to demonstrate a significant interaction. Hogarty *et al.* (1986) was the only study that looked at EE and social skill training. They reported that the relapse rate of social skill training in patients whose families remained as high EE at the one-year follow up was not significantly better than that of controls. Hence it looks as if the effect of improved social functioning, change of EE status and the patients' relapse are more interactive than a simple causal relationship.

3. *What are the active ingredients?*

None of the studies reviewed here directly tested the active ingredients in these multi-component therapeutic packages, other than Tarrier *et al.*'s study. This is probably a reflection of how difficult it is to study the active ingredients of any psychological treatment package. Kazdin & Wilson (1978), O'Leary & Berkovec (1978) and Leff (1981) have all commented on the inadequacy of a placebo treatment in psychological treatments. A placebo psychological treatment that generates the same amount of credibility and expectancy of outcome would probably contain some active ingredients. Tarrier *et al.* attempted to do away with the placebo treatment concept by having two levels of instruction in their behavioural groups. It was hypothesized that the enactive level would be more effective than the symbolic level. Unfortunately, the outcome did not support their prediction. However, the education-only control group showed that education alone did not have any effect on relapse either in the high or low EE groups. It does not look as if education alone contains the sufficient ingredient.

To date, there seem to be enough studies with good research designs to demonstrate the effectiveness of family treatment in schizophrenia. To recapitulate, the effectiveness did not seem to be due to better drug compliance or more contact with the clinical teams. There is also evidence that the effectiveness of these interventions is not simply due to the non-specific effect of working with the family. Hence it could be justified to use a different approach of the dismantling methodology (Kazdin, 1980) in order to tease out the active ingredients from the 'flavours and fillers'. The outcome differences of patients receiving the full treatment can be compared with other groups undergoing variant interventions, each of which lacks one or more specific components of the full package. Part-treatments that produce effects equivalent to those of the full-treatment condition are likely to contain the active ingredients.

Furthermore, some indication by the consumers about the helpful aspects of the intervention packages may throw some light on the active ingredients. Questionnaires on the global satisfaction of the consumers are often unhelpful and tautological. They may involve some subjective averaging of the session or treatment course as a whole. The specific impact of significant interactions between the therapists and the clients is often untapped. The techniques developed by Elliott (1985) and Bloch *et al.* (1979) in which the clients and the therapists were requested to provide a brief account of the helpful events during the sessions may be a more useful way directly to tap into the impact of the therapy on the relatives and patients, giving some indication of possible active ingredients.

4. *What are the common components in these treatment packages?*

A survey of the treatment packages reveals a number of common components in these studies even though the interventions are confusingly labelled as psycho-education, behavioural family work or family therapy/relatives' group. However, most of these approaches have a common heritage stemming from the earlier works of Liberman *et al.* (1978). Berkowitz *et al.* (1990) described in detail the treatment technique used by Leff's team; Hogarty *et al.*'s family treatment was based on Anderson *et al.*'s (1986) psycho-education model; Falloon (1984) published his problem-solving family treatment approach; and finally Barrowclough & Tarrier (1987) described their treatment approach in a paper.

Kottgen *et al.*'s (1984) psychodynamic intervention package is excluded as the study showed no significant effect of their interventions.

A. A positive approach and genuine working relationship In all the above therapeutic models there is an explicit emphasis on the positive aspects of the family and the family's ability to change, rather than blaming the family. Instead the therapists attempt to understand every family member's perspective and emphasize the positive intentions of the family. Hence Falloon's team assumed that the family wanted to help and that the coping behaviour of the family members represented the person's best effort even though it may have looked undesirable to the professionals. Like all the other three models, they focused on the strength and needs of the family unit. Often, the family's intention was positively reframed even though it seemed undesirable to the therapists. Furthermore, the Rogerian principles of empathy, warmth and genuineness are emphasized. Relatives are respected as individuals with their own needs and their burden of caring for a family member suffering from schizophrenia is acknowledged. Hence, families are taught better ways to deal with problems rather than the therapist being punitive with the family's undesirable coping.

B. Providing structure and stability Hogarty's team taught families that intense interpersonal involvement and permissiveness would lead to stress and reinforce inappropriate behaviour. Similar to the model adopted by Leff's and Falloon's teams, relatives were told that patients were more likely to respond to appropriate limit setting while maintaining a moderate interpersonal distance. In all the above therapeutic approaches, contracts of regular contacts were clearly spelled out to provide some structure and stability to the families who might be experiencing a lot of the unpredictability that a schizophrenic patient could bring. Both Leff and Hogarty's teams even made a special effort to be available over the telephone between sessions to exert structure and reinforce coping. Falloon's team provided a 7-day per-week, 24-hour crisis contact service either via the telephone or domiciliary counselling.

C. Focus on 'here and now' In all the intervention packages, the focus of work is the problems and the stress the family faces. During the assessment stages, attempts are made to find out the family's past and present coping strategies and to understand the family's strengths and weaknesses. However, the general emphasis is how the family react to each other, the individual member's perception of the problem and their ways of coping. Moreover the therapist exerted quite a tight control over the family atmosphere by discouraging criticism, over-involvement, permissiveness; and encouraging realistic expectations and better coping strategies.

D. Use of family concepts The models used by Hogarty's and Leff's teams emphasized the importance of avoiding unclear family structures. Hence the therapist attempted to eliminate diffuse generational and interpersonal boundaries by supporting a marital coalition and encouraging respect for interpersonal boundaries. Family boundaries were firmed up by strengthening parental boundaries or marital alliance and promoting independence and separation if appropriate. Falloon's model of behavioural family work had less emphasis on the aforementioned family concepts. However, Falloon's work did emphasize the behavioural analysis of the family unit as a whole, identifying the role that specific problem behaviour plays in the functioning of the family. In working with the family, the assets of the individual members as well as the family unit were called upon to work through problems.

E. Cognitive restructuring The education component provides a model for relatives to make sense both of the patient's and their own behaviour and feelings. Hence the patient is no longer seen to be malicious and deliberately failing to control their very disturbing behaviour. Relatives may also understand that delusional accusation is real to the patient and develop better ways to handle situations rather than heated arguments or counter-accusations. By stating clearly that there is no evidence of schizophrenia being caused by the family, the family education also helps to reduce guilt which is common among these families. In the models used by Leff's and Hogarty's teams, guilt is further reduced for some over-involved relatives by the therapist's assertion that it is important to attend to the relative's own needs in order to be able to cope better.

F. A behavioural approach The family work reviewed above all had the behavioural components of assessing strength and needs, agreeing realistic goals, setting priorities, breaking goals into small behavioural steps, task assignment and reviewing. This behavioural approach was used in Hogarty's and Leff's work with families to set limits, improve patients' functioning and the families' coping. Similarly, Tarrier's team applied detailed behaviour analysis in their intervention. In Falloon's team, these steps were subsumed under a framework of problem-solving. Furthermore, Falloon's team used behavioural strategies to deal with persisting delusions and hallucinations.

G. Improving communication Berkowitz *et al.* (1990) commented on how low EE relatives express their feelings directly, not with anger or any guilt-inducing element. Hence, care is taken to train families to express requests for change in a clear, simple and specific way in the context of problem-solving rather than generalizing. In all the packages some emphasis was placed on communication as a means of correcting erosion of interpersonal boundaries in family units. Family members were trained not to speak for each other and to express clear supportive or reinforcing statements to each other whenever appropriate. With Tarrier's team, communication would be identified as an area of change if it was poor or inadequate. Of all the models reviewed here, Falloon's model was the most explicit in terms of communication training including detailed steps on rehearsal, feedback, coaching, repeated rehearsal, practice and generalization.

5. *What theories could inform psychosocial family treatment in schizophrenia?*

It is important to link theoretical framework with treatment studies as ultimately only theoretical advances could increase the specificity and quality of family interventions. One of the problems in identifying the general mechanisms through which these intervention packages work is the fact that these intervention studies are by and large empirically driven. Despite nearly thirty years of research, EE remains an empirical concept, the origin of which is not understood. Furthermore EE has been shown to have predictive power not just on relapse in schizophrenia, but also on relapse in depression (Vaughn & Leff, 1976; Hooley *et al.* 1986); on success in maintaining weight loss in previously obese women (Fishmann-Havstad & Marston, 1984); and on which families would drop out from the family treatment of anorexia nervosa (Szmuckler *et al.* 1985). Since there is no unified theory incorporating the nature and development of high/low EE families, and since EE has shown predictive validity across a range of conditions, one can only speculate on the broad and general mechanisms that are possible candidates for effecting therapeutic change in these intervention studies.

One general theory that may be important to all these intervention studies is Coping (Lazarus, 1966). Coping refers to the cognitive-behavioural effort to master, reduce or tolerate the internal and/or external demands that are created by the stressful transaction (Folkmann, 1984). A common component in all the successful intervention packages is the use of therapeutic technique to help solve the family problems or reduce them to a tolerable level. By educating and working closely with these families, the therapists taught the families a problem-focused coping approach. As the families learnt more about the nature, outcome and ways to help the patients stay well, their appraisal of the stressor might change, enabling them to assess more objectively their coping resources, including the material assets, social support, etc. Furthermore, the reduction of guilt and the support provided by the therapists could reduce the heightened emotions among the relatives. This reduction in heightened emotion is seen as important for effective coping as heightened arousal interferes with cognitive activities necessary for problem-focused coping (Lazarus, 1966; Sarason, 1972; Khan, 1964). In Tarrier's intervention package, the relatives were explicitly taught relaxation and other cognitive-behavioural techniques to reduce their anxiety. Finally, effective coping involves knowing when to accept a situation which there is very little one can do to change, hence focusing on tolerance or acceptance. Because of the therapists' intimate knowledge of the individual patient, the therapists could advise when to show more acceptance and hold off unrealistic expectation for change. As the patient's clinical state improves, more change is instituted accordingly.

Tarrier (1989) speculated, in keeping the diathesis-stress model, that the way family intervention works is the reduction of stress in the environment. He postulated that if schizophrenic patients have dysfunctions in information processing and arousal regulation, a complex, vague, or emotionally charged environment (typically found in high EE households) would lead to information overload and reappearance of positive symptoms. Conversely, if the environmental stimuli are clear, simple and free of excess emotions, the patients are unlikely to relapse. Hence family intervention works if it succeeds in reducing stress in the environment.

Another theory that might be informative is attribution theory (Weiner, 1986). Leff & Vaughn (1985) and Brewin (1988) postulated that if the relatives believed that the patients had control over their illness, negative symptoms and problem behaviour would elicit criticism and hostility. Emotional over-involvement in relatives is often perceived as a result of guilt, which Weiner (1986) suggested is associated with negative outcomes attributed to internal and controllable causes by oneself. Hence it is tempting to construe success in therapy as associated with attributional change in the relative regarding the onset and symptoms of the illness. Brewin *et al.* (1990) coded spontaneous attributions by relatives in the CFI and found that critical and hostile relatives indeed made more attributions to factors personal to and controllable by the patients, compared with low EE and emotional over-involved relatives. However, the attribution by the emotionally over-involved relatives did not differ from the low EE relatives. Hence the predictions are only partly borne out. However, the number of emotionally over-involved relatives in the study was small and might not have enough statistical power to show any significant difference. Tarrier *et al.*'s (1988) study showed simply providing the family with information about the illness was not effective in preventing relapse or increasing the patients' level of functioning. If the new information is in conflict with the person's pre-existing beliefs, a more structured approach such as trying out different coping strategies to have a different experience may be necessary to effect a shift in beliefs. A study with a larger number of families and attribution measured before and after intervention should shed light on the topic.

CONCLUSION

The family treatments reviewed here consist of labour-intensive packages. However, the beneficial effect of preventing relapse in the first 9 months has been established repeatedly. Even allowing for the intense efforts by the therapeutic teams, the interventions were cost-effective compared to hospital in-patient treatment. Cardin *et al.* (1986) established that the cost of family treatment was 19% less than the control group who needed more crisis management and hospitalization. Furthermore, the benefit for the patients of not being disrupted by frequent hospital admissions is probably beyond that of financial considerations for the health service. Patients would have longer spells to carry through their commitments in the community. Less frequent hospital admissions would probably lead to less stigmatization and better self-esteem.

One criticism is the use of high EE as a selection criterion for intervention. Thus, the needs of the low EE families are by and large neglected (Birchwood & Smith, 1987). The relatives in low EE families may condone or make undue allowance for negative symptoms, thus providing an atmosphere not conducive to promoting the patients' social functioning. This criticism is justified in terms of service provision, in which all client groups should be provided with the best possible care. However, in terms of research, it makes sense to demonstrate the effect of treatment in the 'high risk' group defined on some established criterion such as EE, in order to establish its efficacy. Demonstrating that a treatment package is effective in a defined sub-group of patients does not necessarily mean neglecting the other sub-groups. Whether patients in low EE households respond to some therapeutic approaches to improve their level of social and role functioning is an empirical question that needs to be examined. Schizophrenic patients with negative symptoms may need a different approach. As patients suffering from schizophrenia have such a wide variety of problems, ultimately different strategies may have to be developed.

For further research, a wide variety of outcome measures including the patients' social and role performance, the relatives' level of distress and burden and their subjective report of the impact of the intervention on the family members should be included in addition to patients' relapse. These outcome measures should be taken from different perspectives, e.g. the families, the patients and possibly the therapists. Furthermore, the process of change should be spelled out more carefully and measured. For example, if the aim of the family intervention is to promote more adaptive coping, this should be directly measured before and after intervention in order to promote our understanding of the outcome.

A related but different line of research that is urgently needed is the evaluation of the training of clinicians to use these techniques to work with families. So far, the interventions have been carried out by highly motivated and highly skilled research teams. The replication of the outcomes of such interventions by people who are slightly more distant from such therapeutic packages might make the outcomes more convincing. This would involve packaging the training in a format which would enable ready acquisition of the necessary skills and devising a criterion-based competence scale to facilitate quality assurance and guide trainees to acquire the requisite skills. Furthermore, some process research which involves analysis of the recorded sessions to ensure the therapists' adherence to the treatment manuals is necessary in order to guarantee that the treatment is delivered as intended, and contains the crucial components. The MRC Social and Community Psychiatry Unit is in the process of developing such a training package with appropriate scales to measure competence of trainees and treatment adherence. Tarrier & Barrowclough (1990) also reported their involvement in the evaluation of a systematic training and supervision programme for community psychiatric nurses as well as the development of the Behaviour Family Therapy Skill Measure scale by Laporta *et al.* (1989).

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MOOD DISORDERS

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MOOD DISORDERS

Mood	=	A prolonged emotion that colors the whole psychic life.
Mood Syndrome	=	Group of moods and associated symptoms that occur together for a minimal period of time.
Mood Episode	=	Mood syndrom not due to organic factor; not part of nonmood psychotic disorder.
Mood disorder	=	Pattern of mood episodes.

DEPRESSIVE DISORDERS

Major Depressive Disorder
Dysthymic Disorder
Depressive Disorder NOS

BIPOLAR DISORDERS

Bipolar Disorder I
Bipolar Disorder II
Cyclothymic Disorder
Bipolar Disorder NOS

MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

SUBSTANCE-INDUCED MOOD DISORDER

MOOD DISORDER NOS

I.

CLASSIFICATIONS OF DEPRESSION

KRAEPELINIAN UNITARY CONCEPT

NEUROTIC - PSYCHOTIC DISTINCTION

REACTIVE - ENDOGENOUS

PRIMARY - SECONDARY

UNIPOLAR - BIPOLAR

II. UNIPOLAR vs BIPOLAR DEPRESSION

(1) GENETIC TRANSMISSION: ↑ INCIDENCE OF BIPOLAR RELATIVES IN THE PEDIGREES OF BIPOLAR PATIENTS

(2) SEX DISTRIBUTION: ≈ EQUAL BETWEEN MALES AND FEMALES FOR BIPOLAR DISORDER. IN UNIPOLAR DISORDERS, WOMEN TO MEN 2:1 RATIO.

(3) COURSE OF ILLNESS
AGE OF ONSET = ↓ IN BIPOLAR DEPRESSION
(LATE 20'S) LATER IN UNIPOLAR DEPRESSION
GREATER NUMBER OF EPISODES WITH BIPOLAR

(4) SYMPTOMATIC DIFFERENCES

BIPOLAR VS	UNIPOLAR
HYPERSOMNIA	HYPOSOMNIA
LESS SOMATIC COMPLAINTS	MORE SUBJECTIVE ANXIETY
PSYCHOMOTOR RETARDATION	MORE SOMATIC COMPLAINTS
HIGHER LEVELS OF EXTRAVERSION	PSYCHOMOTOR AGITATION
LITHIUM MORE EFFECTIVE	
ANTIDEPRESSANTS CAN PRECIPITATE MANIC OR HYPOMANIC EPISODE	

III.

CYCLOTHYMIA	VS	DYSTHYMIA
↑ NUMBERS OF BIPOLAR I RELATIVES		EARLIER AGE OF ONSET
↑ LEVELS OF EXTRAVERSION		- EARLY CHILDHOOD
↑ NUMBERS OF GAMILY HISTORY OF SUBSTANCE ABUSE		
BEGINS IN EARLY ADOLESCENCE		

HIGH PROPORTION OF BOTH HAVE LIFETIME HISTORIES OF MAJOR DEPRESSION

IV.

WINOKUR - IOWA CLASSIFICATION SYSTEM

(1) PURE DEPRESSIVE DISEASE = 1° RELATIVE WITH DEPRESSION

(2) DEPRESSION SPECTRUM DISEASE = 1° RELATIVE WITH ALCOHOLISM OR SOCIOPATHY

(3) NO FAMILY HISTORY OF PSYCHIATRIC DISORDER = SPORADIC DEPRESSIVE DISEASE

V.

CLASSIFICATION OF DYSTHYMIA

BASED ON: SLEEP MEASURES
FAMILY HISTORY
COURSE OF ILLNESS
MEDICATION RESPONSIVITY

4 TYPES OF CHRONIC DEPRESSION

(1) SUBAFFECTIVE DYSTHYMIA
    RESPONSE TO TCAs
    SHORTENED REM LATENCY

(2) CHARACTER SPECTRUM DISORDER
    IMPULSIVITY, IMMATURITY, MANIPULATIVENESS

(3) UNREMITTED MAJOR DEPRESSION WITH ONSET IN ADULT LIFE

(4) DYSPHORIC MOOD 2° TO INCAPACITATING MEDICAL DISORDER OR CHRONIC PSYCHIATRIC DISORDER

VI. BIPOLAR II DEPRESSION

EARLY ONSET

TEND TO BE CHRONIC

INTERSPERSED WITH MILD HYPOMANIAS

INFREQUENT EUTHYMIC PERIODS

MILD TO MODERATE IN SEVERITY

HIGH FREQUENCY OF CO-EXISTING NONEFFECTIVE PSYCHOPATHOLOGY

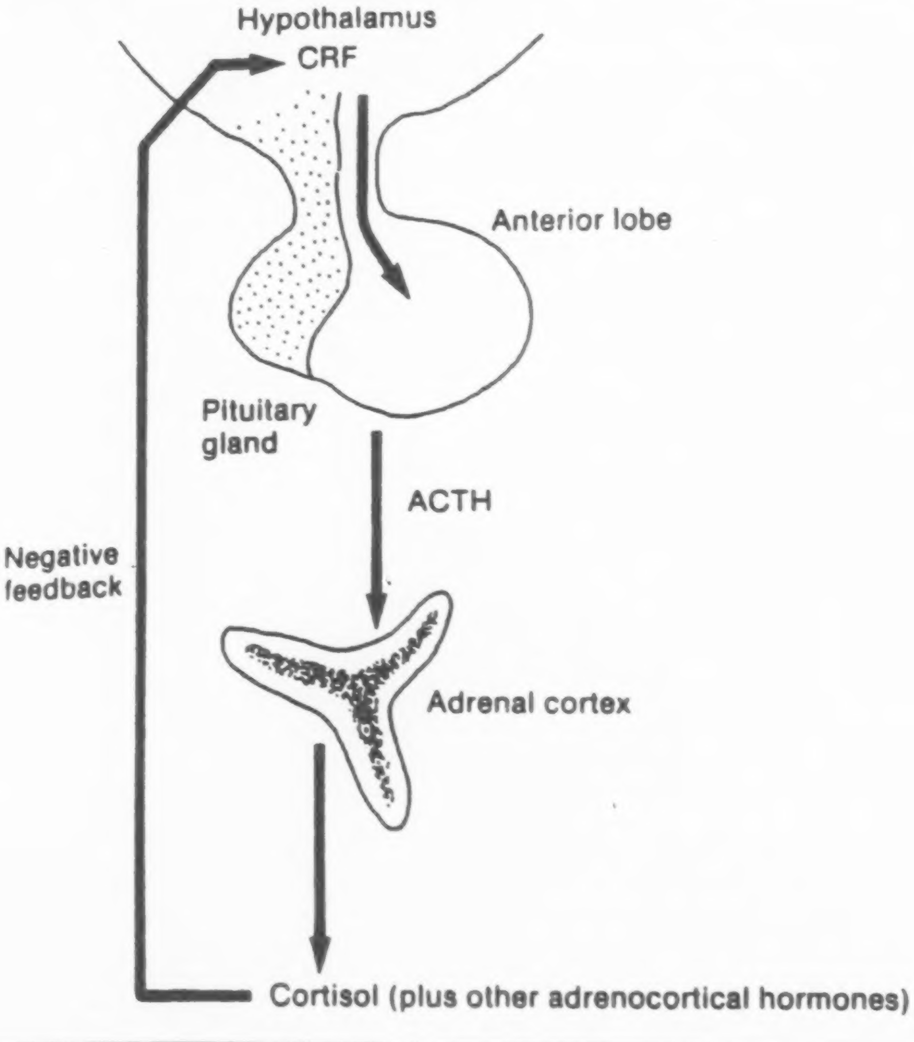
HIGH RISK FOR RELAPSE

MULTIPLE EPISODES

HIGHER RATE OF SUICIDE ATTEMPTS AND COMPLETED SUICIDES

RESPONDS POORLY TO TCAs, SOMEWHAT BETTER WITH MAOIs

FIGURE 2
Hypothalamic-pituitary-adrenal axis


Hypothalamus
CRF
Anterior lobe
Pituitary gland
ACTH
Negative feedback
Adrenal cortex
Cortisol (plus other adrenocortical hormones)

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The Unipolar-Bipolar Distinction in the Characterological Mood Disorders

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The present study explored the validity of the unipolar-bipolar distinction in the characterological mood disorders. Thirteen cyclothymic and 32 primary early-onset dysthymic outpatients, diagnosed according to DSM-III-R, were compared on demographic, clinical, personality, and family history variables. The cyclothymics exhibited significantly higher levels of depressive symptomatology and extraversion and had a higher rate of bipolar I disorder in their first-degree relatives than the dysthymics. In addition, a significantly greater proportion of cyclothymics than dysthymics had a family history of drug abuse. The groups did not differ significantly on gender, overall rates of affective disorders in relatives, or a number of symptoms which have been reported to distinguish unipolar and bipolar depressives. Although these data require replication due to the small sample and large number of analyses conducted, they provide at least partial support for extending the unipolar-bipolar distinction to the characterological mood disorders.

Although it remains controversial (Akiskal, 1983a; Brockington et al., 1982; Taylor and Abrams, 1980), the unipolar-bipolar distinction is the most widely used and best validated subtyping distinction within the affective disorders (Depue and Monroe, 1978; Perris, 1982). In recent years, there has been increasing evidence linking unipolar and bipolar illness to dysthymia and cyclothymia, two forms of chronic mood disturbance that are phenotypically similar to unipolar and bipolar disorder. Thus, cyclothymia appears to be related to bipolar illness with respect to phenomenology, course, family history, neuroendocrine functioning, and pharmacological response (Akiskal et al., 1977; Depue et al., 1981, 1985; Klein et al., 1985). Similarly, studies exploring phenomenology, course, family history, sleep neurophysiology, and pharmacological treatment indicate that there is a relationship between unipolar disorder and at least some forms of dysthymia (Akiskal, 1983b; Klein et al., 1988a, 1988c; Kovacs et al., 1984). These data suggest that cyclothymia and dysthymia may differ in ways that parallel the differences between unipolar and bipolar disorders. Indeed, the unipolar-bipolar distinction was recently extended to the characterological mood disorders in DSM-III-R (American Psychiatric Association [APA], 1987), where cyclothymia is classified as one of the bipolar disorders, and dysthymia is grouped with the depressive disorders. To the best of our knowledge, however, no studies directly comparing cyclothymic and dysthymic subjects have been reported. Hence, as part of a larger study of the assessment and classification of chronic mood disorders (Klein et al., 1988b, 1988c, 1988d, 1989), we compared groups of cyclothymic and dysthymic outpatients to explore the validity of the unipolar-bipolar distinction in the characterological mood disorders.

Unipolar and bipolar depressives appear to differ in a number of respects: a) when depressed, bipolar patients tend to exhibit higher rates of psychomotor retardation and hypersomnia and lower rates of psychomotor agitation, hyposomnia, anxiety, and somatization than unipolar patients (Biegel and Murphy, 1971; Detre et al., 1972, Katz et al., 1982; Kupfer et al., 1974); b) bipolar patients exhibit higher levels of extraversion on personality inventories than unipolar patients (Akiskal et al., 1983; Hirschfeld and Klerman, 1979); c) bipolar patients tend to have an earlier age of onset and a greater number of episodes than unipolar patients (Angst et al., 1973; Depue and Monroe, 1978; Perris, 1966); d) bipolar probands have higher rates of affective, particularly bipolar, disorder in their relatives than unipolar patients (Andreasen et al., 1987; Perris, 1966; Weissman et al., 1984); e) the prevalence of bipolar disorder is approximately equal in men and women, whereas unipolar disorder is approximately twice as common in women as in men

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(Boyd and Weissman, 1982; Perris, 1982; Weissman et al., 1988b); f) lithium appears to be more effective in preventing recurrences in bipolar than unipolar disorder (Prien et al., 1984); and g) antidepressants may precipitate manic or hypomanic episodes in bipolar but not in unipolar patients (Bunney, 1978; Wehr and Goodwin, 1987).

In the present report, we explored whether the demographic, clinical, family history, and personality differences between unipolar and bipolar disorder were also evident in comparisons of cyclothymics and dysthymics. Due to the heterogeneity of dysthymic disorder (Akiskal, 1983b), we limited our dysthymic sample to patients meeting DSM-III-R (APA, 1987) criteria for the primary and early-onset subtypes, as this is the subgroup which corresponds most closely to the classical concept of characterological depression (Klein et al., 1988a, 1988c; Kocsis and Frances, 1987).

Methods

Subjects

Subjects included 13 cyclothymics and 32 primary early-onset dysthymics diagnosed according to DSM-III-R criteria. Six (46%) of the cyclothymics and 19 (59%) of the dysthymics exhibited major depressive episodes superimposed on their chronic minor mood disorders and hence could also be characterized as having bipolar II disorder (Fieve and Dunner, 1975; Spitzer et al., 1978) and double depression (Keller and Shapiro, 1982), respectively. Subjects were drawn from a larger project in which 550 consecutive outpatients at a community mental health center and a university-based clinic were given the General Behavior Inventory (GBI; Depue et al., 1981; Depue and Klein, 1988), a screening inventory for chronic and recurrent unipolar and bipolar affective conditions, before their intake session (see Klein et al., 1989). Using a stratified random sampling method, which sampled disproportionately heavily from the upper range of the distribution of GBI scores, 177 patients were selected and administered a structured diagnostic interview. These subjects were highly representative of the larger population (N = 550) from which they were drawn with respect to age, gender, race, marital status, occupation, and education. When GBI scores were compared with blind diagnoses based on the structured interviews, the GBI exhibited good to excellent negative predictive power and acceptable positive predictive power for chronic unipolar and bipolar conditions (Depue and Klein, 1988; Klein et al., 1989). The cyclothymics and dysthymics had equal probabilities of being selected by the sampling procedure; hence, it was not necessary to weight subjects as a function of the probability of inclusion.

Measures

All patients received structured diagnostic interviews based on the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott and Spitzer, 1978). For the purposes of the present study, however, the SADS was modified in several respects: a) a number of items were added to provide a more thorough assessment of chronic minor mood disorders (Klein et al., 1985, 1986); b) information necessary to derive DSM-III (APA, 1980) diagnoses was elicited. Although the study was initiated before the publication of DSM-III-R, all information necessary to derive DSM-III-R diagnoses of cyclothymia, dysthymia, and the dysthymia subtypes was also available; c) additional sections assessing eating and borderline and schizotypal personality disorders derived from other diagnostic interviews (Robins et al., 1981; Stangl et al., 1985) were included; and d) a section assessing Schneider's (1958) construct of the depressive personality was also included (Akiskal, 1983b). Particular care was taken to ensure that depressive personality traits were scored only if they had been present since early adolescence and were evident outside of major depressive episodes. We have previously reported that the scale has good interrater reliability and is not significantly affected by clinical state (Klein et al., 1988a, 1988c).

Data on all first-degree relatives over age 17 were systematically collected using the Family History Research Diagnostic Criteria (FH-RDC) interview guide (Andreasen et al., 1977). For the present study, the FH-RDC were modified by requiring hospitalization, psychosis, or marked impairment in functioning as a criterion for diagnosing manic disorder. Patients meeting FH-RDC criteria for mania, but not meeting this additional criterion, were diagnosed as hypomanic.

Interviews were administered within the first few treatment sessions by a clinical psychology faculty member and several advanced graduate students. As detailed elsewhere, interrater reliability was excellent (Klein et al., 1988c).

Patients also completed a number of inventories, including the Eysenck Personality Questionnaire (EPQ) extraversion scale (Eysenck and Eysenck, 1975); the Multidimensional Personality Questionnaire (MPQ) achievement scale, a measure of achievement orientation, and abbreviated stress reactivity scale, which is conceptually and empirically closely related to Eysenck's construct of neuroticism (Tellegen, 1982); and the Depressive Experiences Questionnaire (DEQ) dependency and self-criticism scales (Blatt et al., 1976). Data on comorbidity and family history were unavailable for one cyclothymic subject, and two subjects in each group failed to complete the personality inventories.

TABLE 1

Demographic Characteristics of Cyclothymics and Dysthymics

	N	Age	Gender		Race		Marital Status			Education	Socioeconomic Status[a]
			Male	Female	White	Nonwhite	Single	Married	Divorced		
Cyclothymic patients	13	25.6 ± 5.1[b]	5	8	13	0	8	3	2	14.9 ± 2.1	36.7 ± 8.6
Dysthymic patients	32	28.4 ± 7.7	7	25	31	1	18	7	7	14.2 ± 1.9	34.1 ± 11.5

[a] Hollingshead (1975).

[b] $\bar{X} \pm SD$.

Data Analysis

The Weinberg abridged method (Slater and Cowie, 1971) was used to calculate bezugziffers (BZs) for the age-corrected prevalence rates of psychiatric disorders in relatives. The risk periods used were ages 18 to 59 for the affective disorders and ages 18 to 39 for schizophrenia, alcoholism, and drug abuse. Antisocial personality disorder, by definition, is manifested by age 18 (APA, 1980, 1987), hence age corrections were not used for this condition. Typically, differences in morbid risks are calculated by pooling all relatives from all families in each group and computing a modified χ^2 statistic (Breborowicz and Trzebiatowska-Trzeciak, 1976). However, this procedure violates the assumption of independence of observations and can significantly bias results (Fabsitz et al., 1985; Weissman et al., 1986). This problem is compounded in family history, as opposed to family interview studies, where the information on all relatives comes from the same source. Moreover, in family history studies, the traditional procedure substantially inflates the degrees of freedom, because the number of subjects in the analysis is really the number of probands rather than the number of relatives. To address these problems, in the present study age-corrected prevalence rates were calculated separately within the family of each proband, and the family, rather than the relative, was used as the unit of analysis.

Cyclothymics and dysthymics were compared using t-tests for continuous variables and χ^2 tests with Yates correction for categorical variables. Separate, rather than pooled, variance estimates were used for t-tests when the variances differed significantly between groups. All tests were two-tailed.

Results

Demographics

The patients' demographic characteristics are presented in Table 1. The groups did not differ significantly on gender, race, age, education, socioeconomic status, or marital status.

Clinical Characteristics, Comorbidity, and Symptomatology

The data on clinical characteristics and comorbidity are presented in Table 2. As expected, the cyclothymic patients obtained significantly higher scores than the dysthymic patients on the GBI hypomania scale, $t[43] = 7.12$, $p < .001$. However, the groups did not differ significantly on the GBI depression scale.

There was a trend for the dysthymic patients to have an earlier age of onset than the cyclothymic patients, $t[43] = 1.79$, $p = .08$. In contrast, the cyclothymic patients exhibited a significantly higher level of interviewer-rated depressive symptomatology (assessed by summing the severity ratings for all DSM-III major depression and melancholia symptom items) than the dysthymic patients $t[43] = 2.29$, $p < .03$. In addition, there was a trend for the cyclothymic patients to exhibit greater impairment on the Global Assessment Scale (GAS; Endicott et al., 1976) than the dysthymic patients $t[43] = 1.71$, $p < .10$.

The cyclothymic and dysthymic patients did not differ with respect to comorbidity or prior treatment. Most patients in both groups had experienced at least one lifetime episode of major depression after the onset of their characterological mood disorder. In addition, both groups exhibited high rates of comorbid anxiety, substance use, and severe (antisocial, borderline, or schizotypal) personality disorders. Finally, most patients in both groups had sought treatment on multiple occasions in the past.

Cyclothymic and dysthymic patients generally exhibited similar patterns of symptoms, with no differences being evident on rates of psychomotor retardation, hypersomnia, hyposomnia, anxiety, or somatic complaints. However, there was a trend for a greater proportion of cyclothymic (62%) than dysthymic (28%) patients to report psychomotor agitation during their depressed periods, $\chi^2[1] = 3.08$, $p < .08$.

Personality

The cyclothymic patients exhibited a significantly higher level of extraversion on the EPQ ($\bar{X} \pm SD = 14.7 \pm 4.6$) than the dysthymic patients (8.0 ± 5.3), $t[39] = 3.56$, $p < .001$. In addition, there was a trend

TABLE 2

Clinical Characteristics of Cyclothymic and Dysthymic Patients

	N	Age of Onset	Severity of Depression	GAS	GBI		Major Depression[a]	Anxiety Disorder[a]	Eating Disorder[a]	Substance Abuse or Dependence[a]	Antisocial, Borderline, or Schizotypal Personality Disorders	No. of Past Treatment Episodes
					Hypomania	Depression						
Cyclothymic patients	13	11.7 ± 4.3[b]	43.3 ± 4.8	41.2 ± 6.9	18.5 ± 3.7	30.5 ± 7.8	10(77)[c]	8(67)	4(33)	5(42)	6(50)	2.3 ± 1.3
Dysthymic patients	32	9.1 ± 4.4	39.5 ± 5.2	45.8 ± 8.8	7.6 ± 5.0	27.4 ± 7.0	30(94)	18(56)	7(22)	12(38)	15(47)	2.5 ± 1.6

[a] Lifetime DSM-III diagnoses with diagnostic hierarchies suspended.

[b] $\bar{X}$ ± SD.

[c] Numbers in parentheses, percentages.

for the dysthymic patients to exhibit a higher level of depressive personality traits (5.5 ± 1.3) than the cyclothymic patients (4.5 ± 1.3), $t[43] = 1.96$, $p < .06$. The groups did not differ on the MPQ achievement and stress reactivity or DEQ dependency and self-criticism scales.

Family History

The cyclothymic and dysthymic patients did not differ on the number or age and gender distributions of first-degree relatives. A significantly higher proportion of cyclothymic (25%) than dysthymic (0%) patients had a family history of mania, $\chi^2[1] = 5.10$, $p = .02$. Similar proportions of patients in each group had family histories of any affective, bipolar II, and nonbipolar depressive disorder, schizophrenia, alcoholism, and antisocial personality. However, a significantly higher proportion of cyclothymic (42%) than dysthymic (9%) patients had a family history of drug use disorder, $\chi^2[1] = 4.14$, $p = .04$.

The age-corrected lifetime prevalence rates for any affective, bipolar I, bipolar II, and nonbipolar depressive disorder, antisocial personality, alcoholism, and drug use disorder are presented in Table 3. Due to the extremely low rate of schizophrenia in relatives, these data are not presented. Similar to the analyses above, the relatives of cyclothymic probands had a significantly higher rate of bipolar I disorder than the relatives of dysthymic probands, $t[42] = 2.94$, $p = .005$. In addition, there was a trend for the relatives of cyclothymic probands to have a higher rate of drug use disorder than the family members of dysthymic probands, $t[12.2] = 2.02$, $p < .07$.

Discussion

These results provide partial support for the unipolar-bipolar distinction within the characterological mood disorders. Thus, cyclothymic patients reported significantly higher rates of bipolar I disorder in their relatives and exhibited significantly higher levels of extraversion than dysthymic patients. In addition, cyclothymic patients exhibited a significantly higher level of interviewer- but not self-rated depressive symptoms, and a significantly greater proportion had family histories of drug abuse than dysthymics. This last finding should be interpreted cautiously, however, as the difference on rates of drug use disorder in family members only reached a trend level of significance ($p < .07$).

In light of the greater drug abuse in the relatives of cyclothymic than dysthymic probands, it is conceivable that the excess of bipolar I disorder in the cyclothymics' relatives was caused by misdiagnosing behavior due to substance abuse as manic. However, this explanation appears unlikely inasmuch as none of the bipolar I relatives of cyclothymic probands also exhibited alcoholism or drug abuse.

There were also a number of negative findings in the present study. Contrary to expectations, the cyclothymic and dysthymic patients did not differ on gender or overall rates of affective disorders in relatives. In addition, the groups generally exhibited a similar pattern of depressive symptoms.

In the present study, there was a trend for the dysthymic patients to report an earlier age of onset than the cyclothymic patients. Whereas full syndromal bipolar illness typically has an earlier onset than unipolar disorder (Angst et al., 1973; Depue and Monroe, 1978; Perris, 1982), the present data are consistent with reports indicating that cyclothymia typically begins in early adolescence (Akiskal et al., 1977; Depue et al., 1981; Klein et al., 1985), whereas early-onset dysthymia frequently begins in early childhood (Akiskal, 1983b). In addition, this finding is consistent with evidence indicating that whereas prepubertal major depression is not uncommon, mania rarely develops before adolescence (Carlson, 1984).

One of the more striking findings in the present study was the high proportion of cyclothymic and dysthymic patients with lifetime histories of major depression. These data are consistent with previous studies indicating that most patients with characterological

TABLE 3

Lifetime Prevalence of Psychopathology in Relatives of Cyclothymic and Dysthymic Probands

	N	Affective Disorder	Bipolar I Disorder	Bipolar II Disorder	Nonbipolar Depressive Disorder	Antisocial Personality Disorder	Alcoholism	Drug Use Disorder
Cyclothymic patients	12	.56 ± .33	.09 ± .18	.12 ± .19	.38 ± .31	.02 ± .07	.27 ± .25	.17 ± .24
Dysthymic patients	32	.49 ± .29	.00 ± .00	.07 ± .15	.44 ± .28	.06 ± .13	.17 ± .27	.03 ± .09

mood disorders have a history of superimposed major depressive episodes (Keller and Shapiro, 1982; Kocsis and Frances, 1987; Rounsaville et al., 1980). Whereas this is particularly evident in clinical settings, recent evidence suggests that it may also hold for nonclinical samples (Weissman et al., 1988a). In addition, the present study found considerable comorbidity between both cyclothymia and dysthymia and the anxiety, substance use, and personality disorders. These data are also consistent with previous reports of high comorbidity with nonaffective conditions in characterological mood disorders (Akiskal, 1983b; Akiskal et al., 1977; Kocsis and Frances, 1987).

In interpreting the results of the present study, several limitations should be considered. First, the clinical and family history data were not collected independently; hence, it is possible that the higher rate of bipolar I disorder in the relatives of cyclothymic probands rather than dysthymic probands was due to biases created by knowledge of the probands' diagnoses. In addition, relatives were not directly interviewed; hence, it is possible that probands' reports were biased by their own conditions (Cohen, 1988). Whereas these possibilities cannot be excluded, it is important to note that a family history diagnosis of bipolar I disorder in the present study required evidence of hospitalization, psychosis, or marked impairment in functioning. Because these are relatively objective indices of severe psychopathology, this requirement should have minimized the effects of rater and informant bias. In addition, the groups did not differ on the rate of bipolar II disorder in relatives, a "softer," more subjective diagnosis that should be particularly susceptible to rater and informant biases.

Second, the assessments of patients' personalities in the present study were probably biased by their clinical states (Akiskal et al., 1983; Hirschfeld et al., 1983). However, this bias cannot account for the differences between cyclothymic and dysthymic patients on EPQ extraversion, because extraversion seems to be less susceptible to state effects than most personality traits (Hirschfeld et al., 1983). In addition, to the degree that state depression influences extraversion, it should lower scores on this measure. The fact that the cyclothymic patients exhibited a significantly higher level of depressive symptoms than the dysthymic patients would serve to attenuate rather than to inflate group differences.

Third, most patients had experienced superimposed major depressive episodes at some point in their lives. Hence, the present sample did not consist of "pure" cyclothymic and dysthymic patients. As noted above, however, these patients do appear to be representative of cyclothymia and dysthymia in clinical settings (Akiskal, 1983b; Akiskal et al., 1977; Kocsis and Frances, 1987). Moreover, even cyclothymic and dysthymic subjects in the community appear to have high rates of superimposed major depression (Depue et al., 1981; Weissman et al., 1988a).

Finally, the present sample was relatively small; hence, there may not have been sufficient power to detect some significant differences. At the same time, a relatively large number of statistical tests were used, increasing the chances of a type I error. However, the major findings were consistent with the unipolar-bipolar literature and were substantial in magnitude, suggesting that the results are probably valid.

Overall, then, the results of the present study provide at least partial support for extending the unipolar-bipolar distinction from major affective illness to the characterological mood disorders. However, it will be important to replicate this study using a larger sample, "pure" cyclothymic and dysthymic subjects with no history of major depressive episodes, and blind, direct interviews with relatives.

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NIMH/NIH Consensus Development Conference Statement

Mood Disorders: Pharmacologic Prevention of Recurrences

Consensus Development Panel

This report represents the consensus of a panel of representatives from psychiatry, psychology, pharmacology, epidemiology, internal medicine, and the general public regarding the use of pharmacologic agents to prevent recurrences of mood disorders. The panel concluded that recurrent mood disorders, which have a high prevalence and serious consequences, are underdiagnosed and undertreated. Applying appropriate strategies to the management and use of pharmacologic agents will enhance the likelihood of compliance and the prevention of recurrence with a minimum of bothersome side effects. Such strategies should be used within the context of a supportive relationship among doctor, patient, and family.

Am J Psychiatry 142:469–476, 1985)

Mood disorders, also called affective illnesses, are common and serious conditions. It is estimated that at any given time 3% to 4% of the population of the United States will be suffering from a major depressive or manic episode. Recurrences are frequent. During the past decade, clinical and research interest in mood disorders has expanded beyond the treatment of acute episodes to include consideration of long-term maintenance treatment aimed at preventing or reducing the frequency and intensity of further attacks. This broadening of focus has occurred in the context of improved approaches to the description and classification of these disorders and newer epidemiologic studies. Recent evidence has demonstrated the recurrent and chronic nature of these illnesses and the extent to which they represent a continual source of distress and dysfunction for affected individuals and their families, as well as a substantial burden to society. Interest in preventive maintenance treatment has been stimulated further by results from recent long-term trials involving antidepressant drugs and lithium.

The need to consider the longitudinal nature of affective disorders in treatment planning has raised many issues of concern about whether, when, and how to use psychopharmacologic agents to protect patients against recurring episodes of depression or mania. In an effort to resolve questions surrounding these issues, the National Institutes of Health, in conjunction with the National Institute of Mental Health, convened a Consensus Development Conference on Mood Disorders: Pharmacologic Prevention of Recurrences on April 24–26, 1984. After a day and a half of presentations by experts in the field, a consensus panel including representatives of psychiatry, psychology, pharmacology, epidemiology, internal medicine, and the general public considered the scientific evidence and agreed on answers to the following key questions:

1. How common are recurrent mood disorders, and what are the variations in the course of these illnesses?
2. What groups of patients with mood disorders should be considered for preventive maintenance medication?
3. How effective are these medications in modifying the course of recurrent affective illness?
4. What principles guide selection of specific therapeutic agents for these groups?
5. What are the treatment strategies for using these medications on a long-term basis? What additional or alternative strategies are available for breakthrough episodes, treatment failures, or aspects of the illness unresponsive to medication?

From the Consensus Development Conference sponsored by the National Institute of Mental Health and the Office of Medical Applications of Research, National Institutes of Health, April 24–26, 1984. Received Sept. 19, 1984; accepted Nov. 19, 1984. Address reprint requests to Michael J. Bernstein, OMAR, NIH, Bldg. 1, Rm. 216, Bethesda, MD 20205.

The members of the Consensus Development Panel are listed in appendix 1.

An extensive bibliography on recurrent mood disorders is available on request from Mr. Bernstein.

The opinions and conclusions presented in this paper are those of the Consensus Development Panel and do not necessarily reflect the opinions and conclusions of the American Psychiatric Association.

6. What are the long-term risks and complications of preventive maintenance therapy? How should these be assessed and managed?
7. What research areas need further development?

QUESTION 1

How common are recurrent mood disorders, and what are the variations in the course of these illnesses?

Recurrent major mood (affective) disorders are highly prevalent and have serious consequences. These conditions often are not accurately identified by either patients or clinicians and, even when correctly diagnosed, are often undertreated or not treated at all. Precision in differential diagnosis using explicit inclusion and exclusion criteria is essential to the identification and optimal treatment of these disorders.

"Depression" can refer either to a normal mood or to an illness requiring treatment. The normal mood, which consists of those transitory feelings of sadness or discouragement that everyone experiences during difficult times of life, is not what is being discussed in this report but, rather, the specific clinical syndromes of depression and mania. Within this clinical context, the symptoms of depression are many and varied. They may include loss of interest or pleasure in almost all usual activities; poor appetite or weight loss *or* increased appetite or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; decrease in sexual drive; loss of energy; fatigue; feelings of worthlessness, self-reproach, or excessive or inappropriate guilt; difficulty thinking or concentrating; and, most serious, suicidal thinking or attempts. Some individuals with manic syndromes may be euphoric, overconfident, and optimistic. However, their mood is typically brittle and deteriorates rapidly into irritability. Others may only be angry or irritable. These individuals may become more active, restless, and talkative; feel that their thoughts are racing; have an inflated sense of self-esteem; be distracted easily; and engage impulsively in activities that could have severe consequences, such as buying sprees, sexual indiscretions, violent behaviors, or foolish business investments. As a result, mania can be devastating to personal relationships and careers.

For the purposes of this report, a major recurrent mood disorder represents a full-blown syndrome of depression or mania, as defined by criteria set forth in *DSM-III*. Other affective disorders, such as single episodes of depression, chronic milder depression of at least 2 years' duration (dysthymic disorder), and mild depressive or hypomanic syndromes, are discussed only when they occur in patients who also have a recurrent major mood disorder. These other affective disorders also should be recognized as important causes of emotional impairment and often will benefit from treatment, but they are beyond the scope of this consensus statement. Depressive and manic states caused by medical disorders (e.g., hypothyroidism) or exogenous agents (e.g., amphetamines) also are not considered.

The division of major mood disorders into *unipo*[illegible] and *bipolar* subtypes is clinically useful. Patients with unipolar disorder have episodes of depression only; patients with bipolar disorder have either episodes of mania or hypomania and depression or episodes of mania alone. Unipolar disorder is reported to be considerably more prevalent than bipolar disorder. Family and genetic (twin, adoption, and pedigree) studies provide compelling support for strong heritability of these disorders, especially bipolar disorder.

The rates of recurrence, variations in course of illness, and the results of clinical trials in this report are based on studies involving patients who sought treatment at inpatient and outpatient units affiliated with university medical centers. It is premature to generalize from these data on course and outcome for the entire population of persons with treatment mood disorders, which presumably includes a substantial number whose conditions remit spontaneously, who never seek treatment, or who are treated in other settings. However, the treatment recommendations derived from these studies are applicable to patients who suffer major recurrent mood disorders regardless of the setting in which they are seen.

Variations in Patterns of Course of Illness

"Relapse" refers to the exacerbation of an ongo[illegible] episode after an initial suppression of symptoms. "[illegible]currence" refers to a new episode following a complete recovery that has lasted for at least several months. Treatment for preventing a relapse is called "continuation therapy" and is distinguished from longer-term efforts to prevent completely or reduce the intensity and frequency of recurrence ("preventive treatment"). Thus, the sequence of treatment may be 1) an acute phase to control disabling symptoms (may be measured in weeks), 2) a continuation phase to avoid relapses of a single episode (may be measured in months), and 3) a preventive phase to avoid recurrences of new episodes over time (may be measured in years). This report addresses only the third item in the sequence—the preventive treatment of recurrent episodes of affective disorders.

Most of the information presented in this section on course of illness is based on the study of patients whose treatment was not under the control of research investigators, and a substantial proportion of these patients received either minimal or no treatment.

Most patients who have a manic episode go on to have a course marked by multiple recurrences of major depressive and manic episodes. The course of unipolar depression is more variable and less well established. Studies suggest that between 50% and 85% of patients with a major depressive episode who seek treatme[illegible] university medical centers will have at least one su[illegible]quent episode of depression in their lifetime. Between

10% and 15% of unipolar patients will have subsequent episodes that will involve manic or hypomanic symptoms, at which point they are reclassified as having a bipolar disorder. This reclassification occurs less frequently as patients become older and have an increased number of depressive episodes.

Although there are fewer studies of affective disorder in children and adolescents than in adult populations, emerging evidence suggests that these disorders do occur in childhood and, when present, may have a chronic, recurring course. It is reported that the lifetime incidence of major depression is as high as 30% by late adolescence in children who have at least one parent with a major affective illness.

Once mood disorders become recurrent, they have a course marked by high rates of relapse and recurrence and significant morbidity in subsequent episodes and in the intervals between episodes.

Fifteen percent to 20% of patients with a recurrent unipolar disorder do not recover fully from any given episode and have persistent symptoms for at least 2 years. Recently, similar rates have been reported for patients with bipolar disorder, who formerly were believed to have much higher rates of full recovery between episodes.

As many as 50% of patients with recurrent unipolar disorders who recover from a given episode are reported to have a recurrence within the first 2 years after recovery. The likelihood of recurrence is greatest in the 4 to 6 months following initial symptomatic recovery; this risk levels off markedly between 6 and 12 months and is still lower after the patient has been well for 18 months. Some evidence suggests that the length of well intervals between episodes decreases for the first few episodes and then remains steady, while the duration of episodes remains fairly constant. The rate of recurrence in bipolar patients is greater than in patients with unipolar conditions and does not decrease over time.

Some recurrent affective disorders have courses of illness marked by discrete episodes with minimal or no symptoms or impairment in social functioning in the intervals between episodes. Other patients have more insidious onsets of episodes, as well as less complete symptomatic recovery and more impairment in social functioning in the intervals between episodes. The proportion of patients in each of these groups is unknown. Patients who have either of these patterns also may have antecedent or concurrent nonaffective mental disorders.

Factors That Increase Risk of Recurrence

A substantial proportion of patients with recurrent mood disorders also suffer from a dysthymic disorder. If dysthymic symptoms persist after recovery from the major depressive syndrome, the risk of developing new episodes of major depression is especially high. The presence of a nonaffective psychiatric disorder such as alcoholism, drug dependence, or anxiety disorder and an older age at onset also substantially increase the risk of recurrence in unipolar or bipolar recurrent disorders. In addition, the greater the number of previous episodes the patient has had, the higher the risk of recurrence.

Health and Social Consequences

Complications of affective disorders include attempted and completed suicide, increase in deaths from nonpsychiatric medical causes and accidents, impaired social functioning, impaired occupational functioning, impaired parenting, and marital discord. The rates of these events and their severity are substantial.

QUESTION 2

What groups of patients with mood disorders should be considered for preventive maintenance medication?

Before preventive medication is begun, the patient should have a careful medical evaluation to search for organic cause(s) of the affective syndrome or conditions that would contraindicate the use of one or another of the proposed treatments. A comprehensive medical history, physical examination, and appropriate laboratory tests are indicated. This evaluation should include an assessment by, or consultation with, a clinician skilled in the differential diagnosis of mental disorders.

Bipolar Disorder

Patients who have a manic episode are at high risk for recurrences. Manic episodes themselves are very disruptive. The likelihood of becoming psychotic (i.e., having delusions or hallucinations) when manic or depressed is great, and suicide risk is high. Therefore, the occurrence of a manic episode should *always* raise the question of preventive therapy.

Patients who have not had a full-blown manic episode, but have had a hypomanic and a depressive episode, are also at high risk for recurrence and are more likely to become psychotic when depressed than are patients with unipolar disorder. Therefore, careful consideration should be given to implementing preventive therapy in these patients. Other factors in this patient group that indicate a need to consider preventive therapy include number and recency of previous episodes of depression, family history of bipolar disorder, past suicide attempts, past psychotic episodes, past functional incapacity associated with episodes, and level of social functioning or affective symptoms between episodes. Each of these factors tends either to increase the likelihood of recurrence or to be associated with considerable disability and risk should a new episode occur.

Unipolar Disorder

This condition is less frequently recurrent than the bipolar disorders, and the efficacy of the preventive treatments is less clearly established. Therefore, the decision of whether and when to initiate preventive therapy is more highly individualized for patients with unipolar disorders. It depends on identifying those unipolar patients with a high risk of recurrence. The presence of another mental disorder, a chronic medical disorder, or chronic affective symptoms each increases the rate of recurrence, as does older age at the onset of the first depressive episode. Psychotic features, serious suicide attempts, or serious functional impairment during recent episodes all predict increased severity in subsequent episodes. A family history of suicide, bipolar disorder, or psychotic affective episodes also is predictive of increased severity.

Additional Considerations

Additional factors also play a role in the timing and decision to begin preventive therapy in patients who have never had a manic episode. A slow or incomplete response to treatment for a previous episode of depression would lead one to consider preventive therapy more closely. A rapid therapeutic response in a patient with long intervals between episodes argues against the initiation of preventive therapy. The potentially irreparable disruption that a depressive episode may exact on a patient's work, family, and social relationships also would increase the need for preventive therapy. The decision to use preventive treatment is complicated in women who are, or may become, pregnant. Special consideration is also needed for patients who find the presence of side effects disruptive or highly unpleasant. For such patients the decision involves the careful weighing of the potential benefits and risks of preventive treatment.

QUESTION 3

How effective are these medications in modifying the course of recurrent affective illness?

Bipolar Disorder

In a summary of 14 studies of bipolar disorder, the percentage of patients having a recurrent episode of either mania or depression during 1 year after the start of treatment was greatly reduced by lithium maintenance in contrast to placebo. In most of these studies, the number of recurrences was reduced by 50% compared with placebo, and the recurrences were less severe. However, rapidly cycling bipolar patients, i.e., those who have three or more episodes a year, often respond poorly.

Preventive treatment with lithium is equally effective against both manic and depressive recurrences in male and female bipolar patients of all ages from early adulthood to old age; however, there are few d[illegible] available for children and adolescents and for eld[illegible] patients.

The preventive effect of lithium may not develop fully for several months. An early recurrence of bipolar illness following initiation of treatment should not necessarily lead to its abandonment. Antidepressants have not been shown to be effective in preventing recurrence of manic episodes in patients with bipolar disorder.

Unipolar Disorder

Many controlled studies have shown that preventive treatment with lithium or antidepressants (imipramine and amitriptyline) can substantially prevent recurrent episodes of unipolar depression. In most patients, lithium and tricyclics decrease the frequency and/or intensity of recurrences. In six studies with follow-up periods ranging from 5 months to 3 years, the percentages of patients who relapsed or had a recurrence on placebo were significantly greater than the percentages of patients who relapsed or had a recurrence on lithium. In a similar manner, a significant difference between tricyclic antidepressants and placebo was found in several studies. Most studies, however, have found lithium and tricyclics to be equally effective or lithium to be somewhat superior.

Individual patients may respond better to either lithium or tricyclics. One multicenter study sugg[illegible] that patients whose last episode was severe have a better response to imipramine and that patients whose last episode was of only moderate intensity respond equally well to lithium and tricyclics. Research to date has not produced clear-cut guidelines for choosing one over the other when all other factors are equal, nor has it supported the combination of the two as superior to either alone.

Tricyclic antidepressants and lithium prevent recurrences of unipolar depression in both men and women of all ages from early adulthood to old age; however, few data are available for children and adolescents and for the elderly.

Successful prevention of recurrence may involve other important gains for patients, including increased stability of mood during intervals between episodes, regained self-esteem, renewed hope for the future, improved social relations, enhanced vocational abilities, and increased enjoyment of recreational activities.

Because the preventive treatment of recurrent mood disorders is clearly effective for large numbers of persons suffering from these conditions, and because a substantial proportion do not now seek treatment or are not accurately diagnosed, systematic efforts should be made to bring about a greater awareness and understanding by both health professionals and the public of the nature and effective treatment of [illegible] illnesses.

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QUESTION 4

What principles guide selection of specific therapeutic agents for these groups?

Decision to Initiate Preventive Treatment

Repeated and candid discussions with the patient and the patient's spouse or other relatives are mandatory to ensure full understanding of potential advantages and risks of preventive treatment *as well as of no treatment*. These discussions should begin as early as possible after an acute episode is under control. The clinician should have complete information regarding the illness from the patient's and the family's perspective, and it is essential that patients and their families share in the decision-making process. The possible salutary effects of family and job stability should be explained thoroughly, and the known serious and troublesome side effects of each drug under consideration should be made clear. The necessity and importance of long-term monitoring, including required laboratory tests, should be understood fully. Compliance during treatment is improved greatly when all parties understand the therapeutic goals.

Choice of Drugs

Lithium is the drug of choice for preventing recurrences of bipolar disorder. In treating unipolar disorders, both lithium and tricyclic antidepressants have been shown to be effective for prevention. Since most patients will have been treated previously with tricyclic drugs for their depressive episodes, it is usually most appropriate to continue with the same drug, provided it has been effective and is well tolerated. Tricyclic antidepressants also may be preferable in older patients in whom renal function shows a normal decline with age. In addition, elderly individuals are more likely to be using other drugs to treat concurrent illnesses. Either these other agents or the illnesses themselves could interfere with lithium excretion and, thereby, predispose to toxicity. On the other hand, some older patients may be more vulnerable to certain side effects of the tricyclic antidepressants, such as urinary retention, cardiac arrhythmias, and increased intra-ocular pressure. Some clinicians recommend that lithium be used in both bipolar and unipolar patients to minimize the risk of an unexpected manic episode in a patient considered to be unipolar. In particular, lithium may be preferable for patients who have first-degree relatives with a history of bipolar illness or whose psychiatric history is uncertain, since some previously diagnosed unipolar depressions ultimately may prove to be bipolar. The consequences of an unexpected manic episode, which lithium is likely to prevent, are generally serious.

Only a few tricyclic antidepressants have been used in controlled studies of the preventive effect of these agents. It is likely, however, that all standard tricyclic drugs are equally effective, although the question has not been studied empirically. On the other hand, some patients seem to respond to one tricyclic antidepressant after receiving no benefit from another, and side effects will differ from patient to patient and agent to agent. Thus, close monitoring is required, and some sequential courses of treatment with different antidepressants may be indicated.

QUESTION 5

What are the treatment strategies for using these medications on a long-term basis? What additional or alternative strategies are available for breakthrough episodes, treatment failures, or aspects of the illness unresponsive to medication?

Use of Lithium and Tricyclic Antidepressants

Specific clinical guidelines for the use of lithium and tricyclic antidepressants are available in various pharmacologic and psychiatric textbooks as well as articles in professional journals. Unfortunately, despite the interest in various biological tests for the diagnosis and treatment of mood disorders (the dexamethasone suppression test, thyrotropin-releasing hormone test, thyroid-stimulating hormone test, measurement of 3-methoxy-4-hydroxyphenethyleneglycol), no clear-cut guidelines for their use in the treatment of recurrent mood disorders have been established. What follows is only a brief outline of the use of these drugs as preventive agents.

Preventive doses of tricyclic antidepressants have not been adequately defined and, thus, physicians must be flexible in seeking to achieve optimal control. In general, doses similar to or somewhat lower than those used in treating the acute episode have been found effective. Studies of long-term preventive maintenance treatment with tricyclics have not adequately evaluated the effectiveness of dosages greater than 150 mg/day. Lithium in conventional forms is satisfactory. The goal in lithium treatment is to achieve serum concentrations between 0.6 and 0.8 meq/liter in most patients. While some patients may require higher concentrations, in general the physician is advised to maintain the patient on the lowest dose that prevents the return of symptoms because these lower concentrations are associated with fewer side effects.

Duration of Treatment

Duration of treatment must be determined on an individual basis, depending on the previous pattern of episodes, degree of impairment produced, the adverse consequences of a new recurrence, and the patient's ability to tolerate the drug. Data concerning the optimal duration of treatment are lacking. Most clinicians, as well as patients, would be loath to embark on a lifetime course of treatment. If the patient remains free of recurrences during a period equivalent to several of the previous cycle lengths, a decision may be reached to discontinue treatment, provided that a family member or friend of the patient is available to alert the patient and, if necessary, the physician to symptoms of recurrence. In general, the stronger the indications for initiating preventive treatment, the longer its duration should be.

When tricyclics are discontinued after long-term exposure to the drug, the process should be gradual to avoid symptoms that sometimes occur after sudden cessation. Thus, decreases in doses may be spread over weeks or months, with larger decrements early in the withdrawal phase and smaller decrements once the daily dose becomes 50 mg or less. Discontinuation of lithium can be done abruptly or spread out over a couple of weeks. The latter is probably advisable for patients receiving relatively high doses. Neither drug is addictive or prone to abuse.

Breakthrough Episodes

Breakthrough episodes during preventive treatment are manifested by the emergence of clinically significant signs and symptoms of either mania or depression. Purely symptomatic treatment (e.g., sedative hypnotics or anxiolytics) should be delayed at this stage because close assessment over several weeks is desirable to be sure that a clinically significant recurrence of symptoms has occurred. When such breakthroughs occur during lithium treatment, the first step is to check serum lithium levels either to assure compliance or to justify an increased dose. The second step is to check the thyroid status, since hypothyroidism may mimic depression. The third step would be to add to the lithium an antipsychotic for manic breakthroughs or an antidepressant for depressive breakthroughs. These agents, however, should be used only temporarily for relief of the acute symptoms and should be withdrawn when these symptoms abate.

Treatment Failures

If the aforementioned measures fail, other treatments should be tried. Although many alternatives have been suggested, none has been extensively tested. Several reasonable alternatives are the replacement of lithium with carbamazepine, the addition of carbamazepine to lithium, or the replacement of tricyclic antidepressants with monoamine oxidase inhibitors for depressive treatment failures. Electroconvulsive therapy may also be considered for either manic or depressive treatment failures, particularly where suicidal risks seem high.

Some patients, usually those who have frequent and severe recurrences of depression that require large doses of tricyclic antidepressants, may experience more frequent episodes after use of these agents. When such a pattern is recognized, the minimal effective dose of tricyclic should be used. In some cases, allowing a depressive episode to run its course without antidepressant treatment will break the cycle.

Psychological Management of Patients in Preventive Therapy

The problem of patient compliance, especially with lithium, has been well documented in several studies. Medication side effects as well as patient and family attitudes toward these illnesses and their treatment may each contribute to noncompliance. It is believed that the treating physician can make a considerable impact on treatment efficacy by counseling patients who are receiving preventive therapy, interviewing carefully, asking directly about particular side effects, eliciting patients' concerns, treating side effects as indicated, and providing information to ensure optimal adherence.

More specific psychotherapies or brief counseling sessions may be helpful in reducing the secondary consequences of chronic conditions that are often associated with recurrent major affective illness (e.g., occupational or marital disruptions). This treatment may be provided either by the treating physician or by another professional skilled in such services.

Three types of psychotherapy (cognitive, interpersonal, and behavioral) have been found helpful in alleviating depressive symptoms. Whether these specific psychotherapies or others also play an adjunctive role with pharmacotherapy in preventing recurre[illegible] has not been firmly established. Based on our present state of knowledge, for nearly all patients suffering from major recurrent mood disorders, psychotherapy should be used in combination with, not as a substitute for, pharmacotherapy for long-term preventive treatment.

QUESTION 6

What are the long-term risks and complications of preventive maintenance therapy? How should these be assessed and managed?

Adverse Effects of Preventive Treatment

The risks of preventive therapy with lithium or tricyclic antidepressants do not appear to differ appreciably from the adverse reactions to these drugs for treatment of acute episodes of mood disorders, with the exception of impaired thyroid function, which may increase in frequency over time on preventive lithium therapy. Because lower doses are frequently successful for prevention, side effects may, in fact, be less of a problem. The earlier fears of irreversible renal damage now seem to be unwarranted. Except during the first trimester of pregnancy, there are few significant [illegible]manent risks with either lithium or tricyclic ther[illegible] There may be minor renal tubular defects and hypothyroidism brought on by long-term lithium therapy, and a few patients may be at minimal risk for arrhythmias with extended treatment with tricyclic antidepressants. Tricyclics may lead to weight gain, orthostatic hypotension, subtle confusional states, and exacerbation of mania. Lithium may create symptoms of thirst, polyuria, tremor, diarrhea, weight gain, or, less commonly, hypothyroidism. Memory problems, tiredness, and a dulling of senses have been reported as additional complications of lithium that may contribute to noncompliance. Separation of these possible side effects from symptoms of the illness needs to be explored. A carefully supervised reduction in dose, reevaluation of thyroid status, or a therapeutic trial of antidepressants are ways in which the distinction may be achieved. Because patients with mania and depression are at high risk for suicide, supplies of medication should be limited. Adverse consequences of lithium on the fetus and nursing newborn should be made known to women who may become pregnant. Preventive use of lithium and tricyclic antidepressants in children and adolescents must be based on clinical judgment because risks and benefits have yet to be firmly established. Preliminary studies suggest that the potential problems are similar to those seen in adults.

Monitoring for Adverse Effects

Follow-up visits at regular intervals provide an opportunity to assess changes in clinical status, resolve compliance issues, institute appropriate medical interventions, and establish a basis for treatment during breakthrough episodes. More frequent contact is clearly necessary during periods of potential recurrence or change in clinical status. Clinical observation and laboratory tests provide useful benchmarks in the event of complications during long-term treatment. Current practice during treatment with lithium is to monitor serum lithium levels at intervals of 1 to 3 months and to assess serum creatinine values and thyroid-stimulating hormone (TSH) values every 6 to 12 months. Additional studies such as ECGs may be needed to elucidate other adverse effects.

Lithium intoxication is less likely in patients receiving low doses and with low serum concentrations as recommended here for preventive treatment. Patients should be advised always to keep well hydrated and immediately to report intercurrent illnesses that cause vomiting, diarrhea, or fever or treatment with or use of new drugs.

QUESTION 7

What research areas need further development?

There are many deficiencies in our knowledge of how best to prevent recurrent mood disorders.

The fundamental questions that underlie these deficiencies and need to be investigated are the following:

1. Why do some patients develop severe recurrent illnesses while others do not?
2. Why do some patients respond well to preventive treatment while others do not?
3. Why do some patients lose benefits after an initial response to treatment?

Answers to these questions will require information from therapeutic, epidemiologic, neurobiologic, and genetic studies. The results of such studies should elucidate basic mechanisms of the disorders themselves.

Some research strategies would include, for example, studies of high-risk populations (e.g., children of a parent with a mood disorder), development and testing of new therapeutic approaches, and identification of clinical and biochemical predictors of recurrence. The panel feels that priority should be given to the search for new knowledge about the pathogenesis of mood disorders. Such knowledge might then lead to new and more effective therapies for their treatment.

PANEL'S CONCLUSIONS

Recurrent mood disorders have a high prevalence and serious consequences but are currently underdiagnosed and undertreated. There are groups of patients with recurrent mood disorders for whom treatments are available that effectively reduce the frequency and intensity of subsequent episodes. Complete evaluation and careful differential diagnosis are required before initiating long-term preventive treatment. For patients with bipolar disorders, who are particularly likely to suffer recurrences, extensive studies have supported the efficacy of lithium in preventing recurrences.

While unipolar disorder is associated with a reduced rate of recurrence, both lithium and tricyclic antidepressants have been shown to be effective long-term preventive treatments for recurrent unipolar disorder.

Although the long-term use of these agents poses certain risks, they are not appreciably different from those of their use in acute situations. Applying appropriate strategies to the management and use of these drugs will enhance the likelihood of compliance and consequent prevention of recurrences with a minimum of bothersome side effects. Such strategies must be used within the context of an ongoing, supportive relationship among doctor, patient, and family.

Research priorities should be placed on basic research aimed at elucidating the etiology and pathogenesis of major mood disorders and the development of more effective treatments.

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Innovative Somatic Treatments for Depression

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ABSTRACT

This chapter will briefly review the current theories on the biochemical etiology of depression that are contributing toward the development of innovative somatic treatments. A description of clinically approved pharmacological treatments will be described in detail. Investigational pharmacological treatments that have demonstrated a high probability for general clinical use will also be discussed. Finally, a description of sleep deprivation will be included.

INTRODUCTION

A revolutionary breakthrough for the treatment of depression occurred in the 1950s with the serendipitous discoveries that the tricyclic antidepressant (TCA) imipramine (used for agitation) and the monoamine oxidase inhibitor (MAOI) iproniazid, (used in the treatment of tuberculosis) proved to be effective treatments. Throughout the following decades, several other TCA's and MAOI's were ~~formulated~~ that were effective. The first TCA's were the tertiary amines imipramine, amitriptyline, trimipramine and doxepin. However, there are several problems associated with their use, namely the anticholinergic side effects (dry mouth, constipation, blurred vision, and urinary retention), antihistaminic effects (sedation and weight gain) and alpha adrenergic blockade (orthostatic hypotension and reflex tachycardia). Additionally, the TCA's demonstrated a potential to cause or exacerbate cardiac conduction delays. In part because of the adverse events with the tertiary amine TCA's, the secondary amine TCA's were developed. These included desipramine, nortriptyline and protriptyline. Other cyclic agents, amoxapine, maprotiline and trazadone, followed. While these agents showed a slightly improved anticholinergic, antihistaminic and alpha adrenergic side effect profile compared to the tertiary amines, they were no more effective. Some of the newer cyclic agents demonstrated unique side effect profiles; namely, the rare occurrence of priapism reported in male patients taking trazodone, an increased incidence of seizures reported with maprotiline, and the potential risk of tardive dyskinesia associated with amoxapine secondary to its neuroleptic metabolite.

Because they all share a tricyclic or tetracyclic structure, these agents are often referred to as the heterocyclic antidepressants (HCA's). The acute effect of the HCA's involve reducing the re-uptake of norepinephrine and/or serotonin into the neurons, while some HCA's work more specifically on sertonin and others on norepinephrine.

Like the HCA's, several MAOI's have been developed as antidepressants, namely phenelzine (Nardil), isocarboxazid (Marplan) and tranylcypromine (Parnate). The mechanism of action of the MAOI's is through the irreversible inhibition of monoamine oxidase, the enzyme involved in the degradation of norepinephrine and serotonin, thereby increasing the amount of these amines available in the central nervous system.

While having less direct cardiotoxic effects compared to the HCA's, the MAOI's have anticholinergic side effects and more often cause orthostatic hypotension and weight gain. Another limiting factor in the use of MAOI's is the need to restrict tyramine ingestion as well as to avoid sympathomimetic agents to prevent a possible hypertensive/hyperthermic reaction.

In general, both the HCA's and the MAOI's have a delayed onset of two to three weeks. Electroconvulsive therapy (ECT) is another effective treatment for depression with a more rapid onset of action; however, it also has potential side effects, including memory loss.

From the suggested mechanism of these agents evolved several theories of the pathophysiology of depression. Because the conventional antidepressants have acute effects on serotonin and norepinephrine, early theories centered around biogenic amine depletion at specific sites in the central nervous system. Theories progressed to involve possible involvemnet of neurotransmitter receptors, since these agents cause delayed receptor changes on both noradrenergic and serotonin systems that more closely correlated with the antidepressant response. With increased techniques in the identification of new receptors and receptor subtypes, subsystems of previously identified neurotransmitters are being proposed to play a potential role in the pathophysiology of depression. Finally, hypotheses emerged regarding other systems such as GABA, acetylcholine, the neuroendocrine system and circadian rhythm oscillation. No one single mechanism has yet demonstrated a common final biochemical pathway that explains all hypotheses, and many researchers agree that depression is a heterogenous disorder based on different pathophysiological mechanisms with pathology located at various sites within the central nervous system and the body as a whole. This may explain the differential response to treatment by various antidepressants and also why 20-30 percent fail to respond to conventional antidepressant treatments.[1]

Since the release and widespread use of the HCA's and MAOI's, many somatic treatments for depression have been under investigation for improved antidepressant efficacy and to alleviate problems with safety, side effects, delayed onset of action and insufficient efficacy. Some of the investigational treatments are derived from agents already proven to be effective, others are designed based on novel hypotheses of the pathophysiology of depression, and some have been serendipitously found to have antidepressant effects that warrant further investigation. This chapter will review these newer treatments, first describing two recently released antidepressant compounds (fluoxetine and bupropion) and then reviewing promising investigational treatments that may be approved in the future for general use. Further, because of their novel mechanism of action, they may help define the pathophysiology of depression and depressive subtypes.

Fluoxetine (Prozac)

Fluoxetine was the first in a group of compounds known as serotonin reuptake blockers to be approved for use in the United States. Fluoxetine is chemically unrelated to conventional antidepressants and is pharmacologically unique in that it is a selective and potent inhibitor of neuronal serotonin uptake with minimal affinity for muscarinic, histaminic or noradrenergic receptors.[2] Fluoxetine has efficacy comparable to amitriptyline,[3-5] imipramine[6] and doxepin.[7] These clinical trials demonstrated a more favorable side effect profile for fluoxetine when evaluating anticholinergic, antihistaminic and alpha adrenergic side effects. Compared to conventional antidepressant agents, it lacks cardiotoxicity,[8] epileptogenic potential,[9] poses no special risk for the geriatric population[9] and is usually well-tolerated in overdose.[10] Side effects reported most frequently with fluoxetine are nausea, nervousness and insomnia.[10]

Fluoxetine has a plasma half-life of 1-3 days, with an active metabolite, norfluoxetine, whose plasma half-life is 7-15 days. It binds to plasma proteins to the extent of 94 percent.[11] Several drug interactions of clinical concern include the combination of L-tryptophan and fluoxetine since reports of this combination show evidence of severe agitation, restlessness, insomnia and gastrointestinal distress.[9] An increase of TCA levels, when used concomitantly with fluoxetine, has been reported.[12] It is recommended that the clinician wait at least five weeks before starting an MAOI after the discontinuation of fluoxetine, and wait 14 days from the discontinuation of the MAOI to start fluoxetine. This recommendation is based on three fatalities that occurred when tranylcypromine was prescribed

TABLE 1
Investigational Antidepressant Treatments

Heterocyclics
clomipramine (Anafranil)
dothiepin
lofepramine
mianserin
oxaprotiline

Serotonin re-uptake inhibitors
fluvoxamine
sertraline
citalopram
paroxetine
indalpine

Miscellaneous agents
adinazolam (Deracyn)
nefazodone
venlafaxine
fengabine
sulpiride
S-adenosyl-L-methionine (SAM)
methylene blue

Monoamine oxidase inhibitors
Selective agents:
  selegiline (Deprenyl)
  pargyline (Eutonyl)
  clorgyline
Reversible agents:
  moclobemide
  cimoxatone
  amiflamine
  brofaremine

Serotonin ($5\text{-}HT_{1A}$) agonists
buspirone (Buspar)
gepirone
ipsapirone
tandospirone

Nonpharmacological treatments
phototherapy
sleep deprivation

subsequent to fluoxetine.[13] It is suggested that the proximal use of flu an MAOI can have the potential to cause a serotonergic syndrome cl by excitement, diaphoresis, rigidity, hyperthermia, hyperreflexia, coma and possibly death.[13]

Recommended dosing of fluoxetine is 20 mg per day, initially. V per day is adequate treatment of the majority of persons who respond doses as high as 80 mg per day may be warranted, especially in the pa depression is only partially responsive to lower doses. There is evidence that doses less than 20 mg may be effective in some p therefore, alternate-day dosing may be utilized.

Fluoxetine offers the potential benefit of an initial treatment for do not respond to or cannot tolerate the side effects of conventi Further clinical studies are investigating the potential role that flu have in the treatment of other psychiatric disorders, including Obs pulsive and Panic Disorders.

Bupropion (Wellbutrin)

Bupropion is a unicyclic phenylaminoketone with demonstrate sant efficacy. It appears to be chemically and pharmacologically c

le agents. The neurochemical mechanism of bupropion is not known.
pear to inhibit monoamine oxidase, and, compared to the TCA's, is
locker of the neuronal re-uptake of serotonin or norepinephrine.[14]
on bupropion's mechanism of action focuses on the drug's in vivo
aminergic transmission.[14] Bupropion demonstrates antidepressant
ior to placebo[15] and comparable to amitriptyline,[16] doxepin[17] and

Clinical trials have generally demonstrated bupropion to have
ess anticholinergic and antihistaminic associated side effects com-
s and to be well-tolerated in geriatric patients. Bupropion shows no
ificant alterations in pulse, blood pressure or orthostasis when
lacebo in patients who had clinically significant orthostasis hypo-
by TCA's.[19] No significant changes on the electrocardiograph
rted with therapeutic doses of bupropion.[20]

commonly reported side effects include headache, agitation,
omnia,[14] and the most serious adverse reaction encountered is
ion was first approved by the U.S. Food and Drug Administration
ased for general use in 1985. The pharmaceutical company that
pion voluntarily withdrew the drug from the market in 1986 due
incidence of seizures in bulemic patients receiving the drug. The
ased after a more thorough investigation into the incidence of
luation of 4,262 depressed persons receiving bupropion in the
ose range of 450 mg per day or less reports an incidence of
from 0.35 percent to 0.44 percent.[21] Because of these reports, it
that bupropion not be used in persons with a seizure disorder or
or past history of bulimia and/or anorexia, and that dosing not
r day or more than 150 mg in any single dose. Care must also be
g the drug in anyone predisposed to seizures or combining
ments that may also alter seizure threshold.

s limited data on the interaction between bupropion and other
n with other agents, especially those which can lower seizure
be done with caution.

a novel agent with an antidepressant mechanism which is not
d. The drug's apparent unique mechanism of action and side
les the clinician to utilize it as an antidepressant, especially for
unresponsive or could not tolerate the side effects of conven-

HETEROCYCLIC COMPOUNDS

ral heterocyclic compounds under investigation in the United
e of their increased biochemical specificity and/or their more

favorable side effect profile as compared to standard preparations. Many of these compounds are available in other countries, particularly Europe, and demonstrate potential antidepressant properties.

Clomipramine (Anafranil)

Clomipramine is a tricyclic compound whose antidepressant effects were first reported in 1964.[22] It has been widely used throughout the world for the treatment of depression and Obsessive Compulsive Disorder. Clomipramine is approved for the treatment of Obsessive Compulsive Disorder, with or without associated depression, in the United Staes, but lacks FDA approval for the treatment of depression.

Antidepressant efficacy of clomipramine is reported to be superior to placebo,[23,24] and comparable to amitriptyline,[25,26] imipramine,[23,24,27,28] doxepin,[29] and desipramine[30] in controlled studies. Based upon these studies, the side effect profile is generally comparable to the marketed HCA's. Mean daily dose of clomipramine ranges from 75-300 mg per day in the antidepressant efficacy studies.

Compared to the marketed HCA's, clomipramine is a potent re-uptake inhibitor of serotonin,[31] a property to which the drug's therapeutic effect for both depression and Obsessive Compulsive Disorder is at least partially attributed. However, clomipramine has an active metabolite desmethylclomipramine, a norepinephrine re-uptake inhibitor which may also play a role in the compound's antidepressant properties.[32] Because of its long-standing efficacy in the treatment of depression and its availability in the United States to treat Obsessive Compulsive Disorder, it is likely that clomipramine will be used by clinicians to treat depression, especially when accompanied by concomitant Obsessive Compulsive Disorder or in persons unresponsive to conventional treatment.

Dothiepin

Dothiepin is a tricyclic compound structurally similar to amitriptyline and doxepin which has been widely used throughout Europe as an antidepressant since 1964. The antidepressant effects of dothiepin are thought to involve noradrenergic uptake inhibition and possibly enhancement of serotonergic neurotransmission.[33] Dothiepin down-regulates beta-adrenergic[34] and serotonin receptors ($5HT_2$)[35] after chronic administration. Antidepressant efficacy of dothiepin is comparable to amitriptyline,[36-43] imipramine,[44] doxepin,[45,46] maprotiline,[47] fluoxetine[48] and trazadone.[36,49] It also has equivalent anxiolytic effects in anxiety associated with depression when compared to amitriptyline[37] and alprazolam,[50] and one study demonstrated its superiority over amitriptyline in anxiety symptoms associated with depression.[41] The most commonly reported side effects associated with dothiepin include dry mouth, drowsiness, gastrointestinal disorders and dizziness.[33] The side effect profile of dothiepin is reported to be less problematic when compared to amitriptyline and imipramine,[51,52] and appears to be effective and tolerable in the geriatric depressed population.[51,54] The cardiac effects of dothiepin also appear to be less than those of other tricyclics.[53]

Based on the results of the previously described efficacy studies, the therapeutic dose range of dothiepin is between 75–225 mg per day. There is evidence that dothiepin has analgesic benefit in the treatment of fibromyalgia,[55] idiopathic facial pain syndrome[56] and rheumatoid arthritis associated with depression.[57] Several studies are currently under way in the United States that may help further define the role of dothiepin in the treatment of depression and related disorders.

Lofepramine

Lofepramine is a tricyclic agent with desipramine as its major metabolite. It is available in Europe for the treatment of depression, and is under active investigation in the United States. Several studies suggest that lofepramine's antidepressant activity is due to the potent inhibition of norepinephrine re-uptake and that the drug may also potentiate serotonin neurotransmission.[58] Down-regulation of beta-adrenergic receptors is reported with long-term treatment.[59] Double-blind, controlled studies found that lofepramine had antidepressant efficacy when compared to amitriptyline,[60–64] imipramine[65–69] and maprotiline.[58] Lofepramine has a more favorable side effect profile compared to standard TCA's, especially in regard to anticholinergic effects, hypotension[64,66] and cardiovascular side effects.[58] The use of lofepramine in the geriatric depressed population is reported to be both efficacious and remarkably well-tolerated.[70] It remains controversial as to whether the antidepressant effect of lofepramine is solely from the action of its metabolite, desipramine, or whether the drug possesses additional inherent antidepressant properties.

Mianserin

Mianserin is a tetracyclic compound that, in the 1960's while being evaluated for the treatment of migraines, was serendipitously found to have mood-lifting effects. This effect was so marked that the staff at the research center called mianserin the "good humor pill."[71] While there are methodological flaws in a few of the studies, controlled trials suggest mianserin has an antidepressant efficacy superior to placebo[72] and diazepam[73] and comparable to amitriptyline[74,75] and imipramine.[74,76,77] Mianserin appears to have a novel mechanism of action in that it produces a pronounced and acute blockade of presynaptic alpha_2 receptors resulting in increased release of norepinephrine due to the inhibition of the negative feedback loop.[71] Mianserin does not appear to cause beta-receptor down-regulation,[78] and evidence suggests that its long-term administration increases responsiveness to serotonin in the brain.[79] Mianserin is a weak inhibitor of the muscarinic receptor and a potent inhibitor of the histamine receptor (H_1),[80] which may explain its clinically significant lack of anticholinergic and sedative effects. Mianserin is not associated with electrocardiogram changes, including cardiac conduction.[81] Mianserin has been available in Europe for use as an antidepressant and is under active investigation in the United States. It is an agent with suggested novel antidepressant properties and a favorable side effect profile; however, there are reports of blood dyscrasias[82] and seizures[83] associated with its use, which may have an effect on its future marketing in the United States.

Oxaprotiline

Oxaprotiline is a tetracyclic analogue of maprotiline that is a highly selective and potent inhibitor of norepinephrine re-uptake, and is associated with beta-adrenergic down-regulation with subchronic administration.[84,85] There is evidence that oxaprotiline has antidepressant efficacy with no appreciable side effects except for mild anticholinergic effects.[86] A double-blind, partial crossover study, comparing oxaprotiline to fluvoxamine (a selective serotonin re-uptake inhibitor) in a group of depressed patients who failed treatment with a cyclic agent, reports antidepressant efficacy for both agents.[87] It further found that nonresponders to the selective noradrenergic agent did not appear likely to respond to the serotonergic antidepressant fluvoxamine, and vice versa.[87]

MONOAMINE OXIDASE INHIBITORS

Monoamine oxidase (MAO) is an enzyme found in several organ systems (including the brain) that is responsible for the degradation of several amines thought to be involved in the pathophysiology of depression. MAO-A preferentially degrades norepinephrine and serotonin and is responsible for the tyramine reactions seen with MAOI's. MAO-B preferentially degrades dopamine and PEA.[88] The MAOI's presently on the market as antidepressants are nonselective, affecting both MAO-A and MAO-B. They are also known as "irreversible" MAOI's because, when discontinued, the cell requires 2–3 weeks to regenerate new stores of MAO enzyme. Several MAOI's are being investigated to clarify their specific mechanism(s) of action with the hope for either greater efficacy or improved safety.

Selective Monoamine Oxidase Inhibitors

Selegiline (Eldepryl). Selegiline is an irreversible MAOI available in the United States for the supplemental treatment of Parkinson's Disease. In low doses (10 mg per day), it is a selective inhibitor of MAO-B and, therefore, does not alter tyramine sensitivity.[89] Such selectivity may alleviate the need for dietary restrictions; however, in higher doses, selegiline appears to lose its selectivity and involved both MAO-A and MAO-B.[89,90] There is evidence that selegiline elevates brain phenylethylamine (PEA) levels and gives rise to amphetamine and methamphetamine metabolites.[90] Selegiline has been reported to have antidepressant effects in doses selective for MAO-B inhibition when evaluated in open, uncontrolled trials[92-94] and other controlled studies have supported these earlier findings.[95-96] Furthermore, there is evidence that it shows a greater overall improvement in non-endogenous as compared to endogenous depressives,[97] and is possibly effective in atypical depressives.[97] Many of these studies used varying doses of selegiline in both the selective MAO-B dose range and the nonselective ranges. A recent controlled study reports that selegiline is no better than placebo in selective MAO-B doses (10 mg per day); however, its antidepressant efficacy is superior to palcebo in nonselective inhibiting dose ranges (an average of 30 mg per day) and the occurrence of side effects is no greater when compared to palcebo.[96] The overall trend in many of the studies demonstrating selegiline's efficacy suggests increased efficacy in doses between 20–40 mg per day, as well as showing a more favorable side effect profile as compared to conventional MAOI's. The mechanism of antidepressant action postulates the involvement of PEA or dopamine, supported by the efficacy studies using selective MAO-B inhibiting doses; norepinephrine and serotonin, supported by efficacy studies using the nonselective doses; and, possibly involving the direct or indirect effects of its metabolites, amphetamine and methamphetamine.

The potential to slow down the progress of Parkinson's disease by supplementing conventional therapy with selegiline has demonstrated the drug's novelty as a treatment for this disease via retarding the degenerative process.[99] Selegiline demonstrates potential benefits in Alzheimer's disease when used in selective MAO-B doses[100] and may prove to be a useful agent to treat other degenerative processes in the elderly.[99] Its availability for the treatment of Parkinson's Disease may provide a useful therapeutic tool in those who suffer from this disorder and associated depression. Further studies are needed to define its role in the treatment of depression and whether the lower doses associated with MAO-B selectivity are as safe and effective as the non-selective higher doses.

Pargyline (Eutonyl). Pargyline is an irreversible, partially selective inhibitor of MAO-B[101] that was marketed in the United States as an antihypertensive agent up to its withdrawal from pharmaceutical use. Several studies suggest that pargyline possesses antidepressant properties;[102-104] however, no well-controlled studies have been reported, although pargyline-induced mania, a characteristic of potential antidepressant agents, is reported in the literature.[105] The side effect profile of pargyline demonstrates no clear advantages over the present conventional MAOI's, but it may play a potential role in the hypertensive depressed patient.

Clorgyline. Clorgyline is an irreversible selective MAO-A inhibitor that is marketed in Europe, with evidence of antidepressant efficacy based upon studies done in the United States. There is evidence that the efficacy of clorgyline is equal to imipramine[106] and superior to amitriptyline;[107] and, in unipolar and bipolar depressives, superior to pargyline.[108] Further, the use of clorgyline, alone or in combination with lithium, may be effective in cycling bipolar disorders refractory to monotherapy with lithium.[109]

Reversible Monoamine Oxidase Inhibitors

The reversible MAOI's may offer a potential advantage in the treatment of depression in that their effects on MAO metabolism disappears within 1–4 days after drug discontinuation.[110] The rapid return of MAO activity may reduce the likelihood of tyramine-induced hypertensive reactions and make concomitant or proximal use of otherwise contraindicated medications possible. Moclobemide is the most studied of these agents and is a reversible, selective MAO-A inhibitor with an antidepressant profile that compares favorably to amitriptyline.[110] A recent sutdy demonstrated the drug's clear superiority over placebo with an onset of therapeutic activity in 3-7 days and a very mild side effect profile.[111] Other reversible selective MAO-A inhibitors under investigation include cimoxatone, amiflamine and brofaremine.[112]

THE SEROTONIN RE-UPTAKE INHIBITORS

The role of serotonin in affective disorders, coupled with the need for antidepressants with greater specificity and less side effects led to the development of the serotonin re-uptake blockers. There is increasing evidence that these compounds possess antidepressant effects and a side effect profile different than the conventional agents. Zimelidine was the first specific serotonin re-uptake inhibitor to be used as an antidepressant and was available in Europe for clinical use and under investigation in the United States until 1983, when it was withdrawn because of flu-like reactions and reports of Guillain-Barré syndrome.[113] Over the years, several other serotonin re-uptake inhibitors have been developed, with fluoxetine (Prozac) the first, and presently the only, specific compound of this class to be approved in the United States for use as an antidepressant.

All of the serotonin re-uptake inhibitors have a mechanism of action that blocks the re-uptake of serotonin back into the presynaptic neuron resulting in more serotonin in the synaptic cleft. These compounds have little, if any effect on muscarinic, histaminic and alpha-adrenergic receptors, which may explain their more favorable side effect profiles when compared to conventional agents.[114] For this class, the side effect profile is similar to fluoxetine, with the most commonly reported effects being gastrointestinal upset, insomnia and restlessness.[115]

Fluvoxamine

Fluvoxamine is a potent serotonin re-uptake inhibitor available in Europe as an antidepressant and is presently being extensively studied throughout the United States. It is reported to have antidepressant efficacy greater than placebo[116] and comparable to imipramine.[117-120] Reviews of several clinical studies conclude that it does not cause cardiovascular side effects apart from a slight, clinically nonsignificant decrease in heart rate.[121] Fluvoxamine's potential therapeutic benefit is also actively being studied for Obsessive Compulsive and other anxiety disorders.

Sertraline

Sertraline is a serotonin re-uptake inhibitor which possesses up to 10 times the potency of fluvoxamine and five times that of fluoxetine in its serotonin re-uptake properties.[122] Several studies suggest short- and long-term antidepressant efficacy superior to placebo[123,124] and comparable to amitriptyline.[124] Sertraline causes delayed down-regulation of beta-adrenergic receptors.[125] No significant cardiovascular effects have been reported with its use, and it has a side effect profile comparable to other serotonin re-uptake inhibitors.[123] Further studies of sertraline's safety and efficacy in depression and other psychiatric disorders remain active at this time.

Citalopram

Citalopram is a potent inhibitor of serotonin re-uptake with no effect on the re-uptake of norepinephrine or dopamine. The compound has no anticholinergic, antihistaminic or alpha-adrenergic properties.[126,127] Citalopram is presently available in Denmark and has been actively studied in other European countries as an antidepressant. Open clinical trials indicate that citalopram is an effective antidepressant with little or no anticholinergic or cardiovascular side effects.[128-132] Controlled studies indicate that citalopram has antidepressant efficacy comparable to maprotiline[133] and amitriptyline.[134,135] The most commonly reported side effects associated with citalopram include nausea, headache and sweating. A double-blind, crossover study reports a decreased alcohol intake in "early-stage problem drinkers.[136]

Other Agents

Other specific serotonin re-uptake blockers under early investigation include paroxetine[137] and indalpine.[138]

THE SEROTONERGIC 5-HT_{1A} AGONISTS

Several new agents have been developed called the partial 5-HT_{1A} agonists. Four of these have been extensively studied and demonstrate anxiolytic and possibly antidepressant properties. These agents include buspirone (Buspar),[139,140] gepirone,[141] and tandospirone (data on file Pfizer) and ipsapirone (data on file Bayer). All of these agents have similar chemical structures. They may prove to be of particular benefit in the treatment of anxiety due to their side effect profile, including a lack of impaired psychomotor functioning and a lack of abuse potential. However, their onset of anxiolytic action can take up to three weeks.

There is also increasing evidence that the 5-HT_{1A} agonists may have antidepressant properties. Animal models that predict antidepressant efficacy are favorable for the 5-HT_{1A} agonists.[142] Buspirone, presently marketed in the United States as an anxiolytic agent, is reported to have antidepressant effects in man.[143-146] Preliminary trials with ipsapirone, gepirone and tandospirone are suggestive of antidepressant activity.[147] The mechanism of the anxiolytic as well as possbile antidepressant action of these drugs has yet to be fully elucidated, as their neuropharmacology is complex and several of them demonstrate their own novel and intrinsic properties. While these drugs are considered 5-HT_{1A} agonists, there is also evidence that they have 5-HT_{1A} antagonist properties as well.[148]

Buspirone and gepirone have little affinity for alpha-adrenergic binding sites, but show alpha$_1$-adrenergic activity in some models.[149] Gepirone and buspirone have demonstrated decreased 5-HT_2 sensitivity after continuous treatment.[150] Finally, buspirone has mild dopaminergic activity, increases acetylcholine turnover, and may decrease GABA tone.[151,152] While having specific effects on the 5-HT_{1A} receptor, these agents also have other neurochemical effects that may be influential on their anxiolytic or potential antidepressant mechanisms. Further studies with the 5-HT_{1A} agonists are currently under way to confirm their efficacy and safety in depression, Generalized Anxiety Disorder, Panic Disorder, Obsessive Compulsive Disorder, Impulse Control Disorders, and Alcoholism.

MISCELLANEOUS COMPOUNDS

Several compounds that differ from the previously mentioned agents, either because of their novel chemical structure or because of their mechanism(s) of action, will now be discussed.

Adinazolam(Deracyn)

Alprazolam (Xanax) is a triazolobenzodiazepine presently marketed as an anxiolytic (with a neurochemical profile different than the classical benzodiazepines) that is reported to have specific antidepressant effects when compared to standard tricyclic antidepressants.[153-158] A new triazolobenzodiazepine, adinazolam, is being used in Europe and has been under active investigation in the United States as an antidepressant. Several well-controlled studies report the antidepressant superiority of adinazolam over placebo[159-162] and comparable to imipramine[163] and amitriptyline.[164] Finally, this agent has also been reported to induce mania.[165] The above-mentioned studies suggest that adinazolam has a rapid onset of action (often within two to seven days) and that the side effects more than placebo were transient drowsiness, confusion and decreased memory. Its antidepressant mechanism remains unclear. The compound binds to the benzodiazepine receptor; however, unlike classical benzodiazepines, after long-term treatment, it sensitizes neurons to serotonin.[79] Adinazolam does not block the reuptake of serotonin or cause beta-adrenergic receptor down-regulation.[166] In summary, it is a novel compound, with possible rapid antidepressant effects that lacks many of the side effects of conventional antidepressants. Further studies are warranted to determine its role in the treatment of depression.

Nefazodone

Nefazodone is a non-tricyclic triazolo structure chemically related to trazodone, with a pharmacological profile distinct from the heterocyclic antidepressant agents (data on file Bristol-Myers). The compound has potent and complex effects on serotonin receptors and modest effect on noradrenergic receptors, with little or no anticholinergic effects. Nefazodone is less potent than trazodone in its alpha blocking properties. Preliminary data from early clinical trials demonstrates the safety and indicates that the drug has antidepressant efficacy superior to placebo and comparable to imipramine. Several other clinical trials are underway to elaborate on the results of these early clinical trials.

Venlafaxine

Venlafaxine is a structurally novel compound that inhibits the neuronal uptake of norepinephrine, serotonin, and dopamine. It does not have any monoamine oxidase inhibiting activity and shows no affinity for rat brain muscarinic, histaminic, or noradrenergic receptors. It also demonstrates an acute onset of noradrenergic receptor down-regulation, compared to conventional antidepressants that require chronic administration for down-regulation to occur. Studies performed in the United States suggest venlafaxine has antidepressant properties and has a well-tolerated side effect profile.[167] Further studies are underway to determine the role of venlafaxine in the treatment of depression.

Fengabine

The predominant biological theories of depression focus on the central nervous system neurotransmitters norepinephrine, serotonin, and dopamine. More recently, the neurotransmitter GABA has been implicated in affective disorders. Drugs with GABAergic activity such as clonazepam, valproic acid, and carbamazapine all have therapeutic relevance in the treatment of affective disorders, especially bipolar disorder.[168-170] The GABA system is thought to play a possible role in the etiology of depression. There is evidence of a deficit in the GABAergic mechanisms in animal models for depression.[171] In fact, all TCA's and MAOI's, when administered repeatedly, cause up-regulation of specific GABA sites.[172] The GABA hypothesis of depression is most strongly supported by the reported antidepressant activity of GABA receptor agonists. Fengabine is one such GABA agonist that increases norepinephrine turnover and causes desensitization of beta-adrenergic receptor-linked adenylate-cyclase.[173] It does not modify beta, alpha, or alpha$_2$ receptors and is devoid of monoamine oxidase inhibiting activity.[171,173,174] A review of six double-blind studies reports that fengabine has comparable efficacy to amitriptyline, imipramine, and clomipramine in the treatment of depressive disorders. Side effects are reported to be more frequent in the comparison groups compared to those with fengabine.[173] However, one must be cautious regarding the conclusion of this review, since the total population of patients studied in these samples included not only persons with a diagnosis of unipolar depression, but also bipolar depressives, "minor" depressives, dysthymia, atypical depressives, and adjustment disorders with depressed mood. Despite the lack of uniform diagnosis in the studies of the drug's antidepressant efficacy, fengabine and pharmacologically related compounds continue to be studied.

Sulpiride

There is evidence in the literature that several neuroleptic agents possess antidepressant properties. Among the neuroleptics cited for antidepressant activity include thioridazine and perphenazine.[112] Obviously, these compounds carry the risk of any neuroleptic treatment, including tardive dyskinesia. The neuroleptic sulpiride is used in Europe for a number of psychiatric disorders. The potential for causing extrapyramidal side effects, sedation, and tardive dyskinesia is reported less with sulpiride than with other neuroleptics.[175-179] Several studies report antidepressant efficacy of sulpiride in depression.[180-182] The mechanism of pharmocological action of sulpiride differs from classic neuroleptics in several ways. Sulpiride demonstrates a preference for the pre-synaptic dopamine receptor and down-regulates dopamine auto-receptors.[183] The drug also antagonizes adrenergic receptors and mildly blocks post-synaptic adrenergic receptors.[180] Whether these mechanisms are involved in its proposed antidepressant activity has yet to be determined. While there are methodological flaws in the studies suggesting antidepressant properties of sulpiride, further controlled trials of the drug are warranted in persons with depression, depression associated with psychotic features, and schizoaffective disorder.

S-Adenosyl-L-Methionine(SAM)

SAM is an endogenous substance in mammalian tissue that shows potential mood-elevating effects in man.[184] Available for use in Europe, SAM has medicinal usefulness in several disorders, particularly for the treatment of osteoarthritis.[185] The first mood-elevating effects of SAM were discovered serendipitously in the 1970's when the substance was being investigated in schizophrenia and found to have mood-elevating properties.[186] Several open-label and single-blind trials suggest antidepressant effects of SAM using intravenous or intramuscular routes of administration.[187,188] Several double-blind trials reported SAM was equal or more effective antidepressant effects compared to amitriptyline, imipramine, and clomipramine.[189-191] In general, these studies show a trend toward a more rapid onset of action and less, if any, side effects with SAM. Precipitation of mania/hypomania has been reported with the use of SAM.[192] Its mechanism of antidepressant action remains unknown; however, the substance is an endogenous methyl donor for several central nervous system neurotransmitters, including serotonin, norepinephrine, and dopamine, all of which are implicated in the pathophysiology of depression.[188] SAM also has effects on the lipid composition of cell membranes, which may also be involved in the pathophysiology of affective disorders.[193] SAM also increases folate activity, which may also be involved in the pathogenesis of depressive disorders.[194] All of the abovementioned studies are based on the use of intramuscular or intravenous routes of administration. The reason for this route of administration versus oral routes is based on limited investigation of the pharmacokinetics of SAM, suggesting that it has an unstable oral bioavailability. However, a recent open-label study using oral

SAM suggests antidepressant efficacy.[186] Further investigation into its oral bioavailability as well as further contolled studies using it in oral form are now proceeding. The evidence thus far suggests that SAM is a novel antidepressant agent.

Methylene Blue

Methylene blue is a compound that is used in the treatment of various urological disorders. It is involved in the metabolism of vanadium, which has been implicated in the pathophysiology of bipolar disorder.[195] There is evidence that changes in the membrane transport of sodium may be of etiological importance in bipolar disorder and that alterations of plasma vanadium levels may be linked to such changes.[196,197] Methylene blue is reported to be of potential benefit in the treatment of both mania and depression.[198–200]

SLEEP DEPRIVATION

It is firmly established that depression is associated with disturbances in sleep architecture, such as a decreased REM latency, decreased delta sleep, and intermittent wakefulness. It is also reported that antidepressants and electroconvulsive therapy can reverse these depression-associated sleep disturbances.[201] The 1960's heralded the first reported observation that sleep deprivation may be beneficial in the alleviation of depressive symptoms and can produce profound improvement in depressive symptoms within 24 hours.[202] A recent review of studies involving over 1,700 subjects report that an average of 59 percent of patients show a marked improvement of depressive symptoms the following day after a night of total sleep deprivation. Sixty-seven percent of subjects diagnosed with "endogenous" depression responded to sleep deprivation, with no difference noted between bipolar and unipolar depressives. Persons with "neurotic" depression had a response rate of 48 percent. Eighty-three percent of patients not receiving antidepressant medications relapsed into depression after the first night of sleep, compared with 59 percent on medication.[203] Lithium may also prevent a relapse in persons who show a positive response to sleep deprivation.[204,205]

Conclusion

Since the advent of the TCA's and MAOI's in the 1950's and 1960's, there has been continued need to develop new antidepressants that have increased safety, less side effects, increased rapidity of response, and improved efficacy, especially in a subgroup who do not respond to conventional treatments. With the recent introduction of drugs such as fluoxetine and bupropion, increased safety, greater specificity of biochemical mechanism, and/or a more favorable side effect profile has become available. However, these newer agents have side effects of their own, have not yet shown superiority over conventional antidepressants, and do not appear to fully alleviate the problem of depressive subtypes resistant to conventional somatic treatments.

Several agents, with potential antidepressant activity are either being used in other countries and/or are being investigated in the United States. Some of them are developed because of the similar chemical or pharmacological properties of other antidepressants; others are found serendipitously and found to have novel antidepressant mechanisms With the advent of such potential agents, combined with improved research tools, several biochemical theories of depression have evolved. From the early theories of central amine depletion to present theories involving other neurotransmitters (i.e., GABA), receptor characteristics, and neuropeptides, most theories emerge from speculative action of antidepressant agents, and no final common biochemical pathway has been found for all of these agents. It is likely that depression is not a biologically homogenous disorder, but one that consists of various subtypes characterized by different responses to treatment.

To better define the specific antidepressant effects (and depressive subtypes), it is necessary to study new drugs in uniformly defined patients, a methodological drawback of many drug studies published in the literature. It is also important to include data on known depressive subtypes, namely atypical depression, depression with psychotic featuress, bipolar depression, dysthymia, and refractory depression. These subgroups are often excluded from initial antidepressant efficacy studies, yet make up a significant group for whom novel antidepressants may benefit. If potential antidepressant agents under early investigation show efficacy in only a minority of those treated, such agents should not be abandoned, but should be more actively investigated in depressive subtypes. The development of innovative antidepressants combined with more precise research approaches holds great promise for the understanding and treatment of affective disorders.

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Long-Term Treatments of Recurrent Depressive Disorders

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Many, if not most, depressive disorders become recurrent conditions. It is now clear that virtually all recently remitted patients should receive 4 to 6 months of continuation therapy. Moreover, this phase of treatment should continue until the patient has achieved a clear-cut, durable period of recovery. Further, an extended course of maintenance pharmacotherapy is recommended for those patients at risk for subsequent recurrent episodes. In this paper, the rationale for long-term treatment is presented and common strategies are reviewed. Depressive disorders appear to become more autonomous, severe, and potentially refractory with each new episode. Thus, prevention of recurrent depression remains the best available strategy to ensure an optimal long-term outcome for patients with recurrent affective disorders.

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The major mood disorders are best understood as potentially recurrent and chronic conditions.[1-5] Both major depressive disorder and bipolar affective disorder convey a high likelihood of recurrence, and each new episode carries renewed risks of chronicity, psychosocial impairment, and suicide.[2-7] It is no longer sufficient to focus on resolution of acute symptomatology as the principal goal of treatment. Treatment strategies that provide long-term, preventative efficacy also are necessary in contemporary psychiatric practice. In this paper, issues pertaining to the use of long-term, prophylactic treatment strategies for depressive states are reviewed.

THE NATURAL HISTORY OF DEPRESSION

Recent epidemiologic studies suggest that the age at onset of a first episode of mood disorder is becoming progressively younger[8] and, among younger age cohorts, the incidence of affective disorders appears to be increasing.[8,9] Thus, the already considerable public health significance of the affective disorders will most certainly increase in the future.

About 10% of diagnosable cases of major affective disorder are bipolar.[2,7,10] Moreover, the number of chronic and recurrent cases exceeds the number of acute, first-episode disorders.[10,11] Reviews of the literature by Angst[2] and Zis and Goodwin[3] documented the high rates of relapse and recurrence in affective disorders in the 1970s. These findings subsequently were confirmed prospectively in a series of studies conducted under the auspices of the National Institute of Mental Health Collaborative Study on the Psychobiology of Depression (summarized by Keller[6]). If one assumes a lifetime risk for major depression of 5%,[2] an individual who has recovered from an initial episode of depression has at least a 10-fold greater risk of suffering another episode when compared to a person who has never been clinically depressed.[6] Further, bipolar and recurrent (unipolar) major depressions have at least a 70% risk of subsequent recurrences, i.e., a 12-fold elevation in risk compared to that in the general population.[2,7] Chronic minor depressions (i.e., dysthymia) have up to a 90% risk of subsequent major episodes.[6]

It is likely that the majority of depressed individuals in the United States continue to be either untreated or incorrectly diagnosed and/or inadequately treated.[13,14] While this state of affairs may be maintained by societal attitudes and stigma,[15] it also points to the generally favorable short-term prognosis of the mood disorders.[4-7] For example, even without definitive treatment most episodes of depressions last no longer than 1 year and between 80% and 90% have remitted within 2 years.[6,16] However, even such time-limited episodes of depression convey manifold adverse economic, interpersonal, and medical consequences.[3,7,17-20] For example, family dysfunction is quite common even in acute depressive epi-

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sodes, and may persist despite subsequent clinical remission.[18] Impairments in leisure time pursuit and vocational functioning similarly may persist long after resolution of a depressive episode.[19,20] Further, alcoholism, sedativism, or other substance abuse may develop secondary to an untreated depressive syndrome,[21,22] and many depressed patients are heavy tobacco users.[23] And, for the unlucky proportion who do not remit spontaneously, an ingrained pattern of chronic depression conveys even more negative prognostic implications.[7,24]

In major depressive episodes, the onset of the syndrome often develops insidiously, i.e., over a matter of weeks or months.[7,24] In such cases prodromal symptoms may be identified that herald the onset of a major episode, including anxiety, irritability, changes in hedonic capacity, and poor concentration.[24] While most initial episodes of depression occur at times of life stress, only a minority of persons encountering such difficulties develop persistent depressive syndromes, which points to the role of underlying psychobiological vulnerability factors.[25] Such risk factors include a family history of affective disorder or alcoholism, a long-established pattern of maladaptive cognitive traits or interpersonal difficulties, chronic medical problems, or a history of early trauma or abuse.[18,19,21,22] Further, individuals with dysthymic disorder antedating the onset of a major depressive episode typically have a significantly greater number of vulnerability factors than acutely depressive patients with "well" baselines.[9,21,25] In more protracted depressive syndromes, it often is difficult to distinguish between those psychosocial and interpersonal factors that are antecedent to the affective illness and those factors that are consequences.[7]

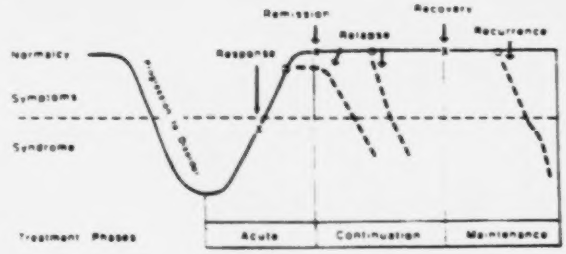
PHASES OF THE TREATMENT OF UNIPOLAR DEPRESSIVE DISORDER

An episode of unipolar depression is schematized in Figure 1. In this illustration, treatment is initiated at the nadir of the depressive episode and possible outcomes are defined by the "5 Rs": response, remission, relapse, recovery, and recurrence.[26] (A sixth possible "R," refractory depression, will not be discussed further in this manuscript.) The relationships between these outcomes and three interlocking phases of treatment, acute, continuation, and maintenance therapy, are described below.

Acute Treatment

The treatment modality first chosen for a depressive episode is generally predetermined by the patient's choice of mental health providers. For example, depressed persons treated by family practitioners are likely to receive pharmacotherapy and practical advice, whereas the clients of psychologists, social workers, and other therapists are almost certain to receive counseling or psychotherapy.[27] At present, most psychiatrists seem to prefer using a combination of both modalities.[27,28] Better means of matching patients with potentially effective treatments would be preferred.

Figure 1. A Diagram of Five Possible Outcomes (Response, Remission, Relapse, Recovery, and Recurrence) During the Three Phases of Treatment of Depression (Acute, Continuation, and Maintenance)*



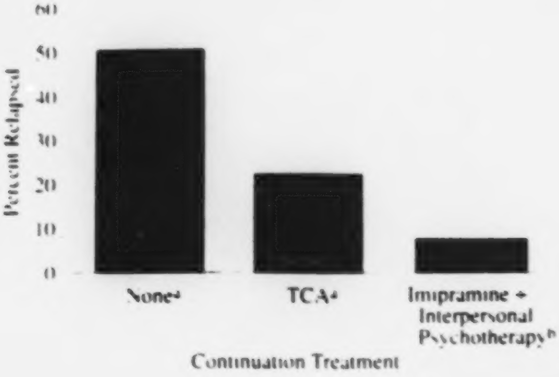
*From reference 122 with permission

Regardless of which type of treatment is chosen, it is useful to conceptualize the initial therapeutic goal as a "treatment response." The term *treatment response* must be qualified by the fact that this outcome encompasses spontaneous remission and placebo response as well as a more specific response to the active treatment. A response generally corresponds to at least a 40% to 60% reduction of symptoms[29] and often can be achieved within 3 to 6 weeks after the initiation of antidepressant pharmacotherapy. Several newer forms of time-limited psychotherapy, which are available in manual form, such as Beck and colleagues' Cognitive Behavior Therapy (CBT)[30] and Klerman and colleagues' Interpersonal Psychotherapy (IPT),[31] appear to achieve comparable results over 12- to 16-week courses in uncomplicated outpatient cases.[32,33] In either case, however, failure to achieve a treatment response after an appropriately maximal trial (e.g., 6 to 8 weeks for pharmacotherapy and 12 to 16 weeks for psychotherapy) should lead the clinician to consider an alternate first-line treatment. Sequential courses of acute therapy thus should be provided until a patient achieves a clear-cut response.[34]

Stabilization and Continuation Therapy

The goals of the next phase of treatment, referred to as stabilization or continuation therapy, are (1) prevention of relapse and (2) "conversion" of a response into a remission.[1] Remission is defined as a level of functioning consistent with the patient's premorbid or "well" self.[1,26] During continuation therapy, the frequency of visits typically is reduced to every other week and, subsequently, monthly as the patient's remission solidif By convention, a stable remission must last for at least to 6 months before it is assumed that the patient has re-

Figure 2. A Comparison of Relapse Rates During the Continuation Phase of Treatment With Placebo, Tricyclic Antidepressants, or Combined Treatment



[a]Data from reference 35
[b]Data from reference 36

covered from the index depressive episode. Relapse, then, is defined by a return of depressive symptoms at a syndromal level at any time point between the initial treatment response and the end of continuation therapy. Reviews of empirical studies of pharmacologic treatments indicate that the risk of relapse is particularly high following withdrawal of an antidepressant during the first 4 months after response: rates typically range from 40% to 60%, compared to relapse rates of only 10% to 30% during continuation pharmacotherapy. Moreover, in our research experience at the University of Pittsburgh, provision of continued full-dose antidepressant pharmacotherapy in combination with interpersonal psychotherapy (IPT) reduces the risk of relapse to an almost negligible rate (see Figure 2). Although systematic studies have not yet been completed in samples of chronic, treatment-resistant, and/or atypical cases, continuation pharmacotherapy with imipramine, phenelzine, and tranylcypromine also appears to have significant prophylactic effects in preventing relapse in these more difficult depressive states.

Beyond premature withdrawal of pharmacotherapy, other risk factors for relapse include chronicity and severity of the index episode, noncompliance with treatment, the presence of residual (subsyndromal) depressive symptoms, severe personality pathology, older age, high levels of dysfunctional attitudes, poor social support, and ongoing or renewed psychosocial stressors.

Depressive relapse also is observed following termination of time-limited psychotherapy. For example, in a study conducted by our group at the University of Pittsburgh, patients treated with the CBT of Beck et al. had a 31% relapse rate during the first year of follow-up, including 52% of the "responders" who had not achieved an 8-week remission prior to termination of therapy. Further, we found that relapsers were more severely ill at baseline, had higher levels of dysfunctional attitudes, and were less likely to be married. Thus, something akin to "continuation psychotherapy" may need to be developed to lessen the risk of relapse in high-risk cases following termination of a time-limited psychotherapy treatment protocol.

The continuation phase of therapy ends when the patient meets criteria for recovery (i.e., after 4 to 6 months of sustained euthymia). As will be discussed later in this review, it is hypothesized that the psychobiological correlates of the acute illness state have become quiescent during recovery. Thus, a renewed period of depressive symptoms following recovery is conceptualized as the onset of a distinctly new episode of affective illness. However, because 10% to 15% of apparently recovered patients suffer recurrences within the first 8 weeks of discontinuing antidepressant medication, it appears that time alone may not provide an adequate definition of recovery.

In some cases, it is difficult to distinguish between a precipitous symptomatic recurrence and anticholinergic withdrawal phenomena. Anticholinergic withdrawal symptoms are elicited by too rapid a reduction in the dosage of selected heterocyclic agents, particularly tertiary amine tricyclics such as amitriptyline, imipramine, and clomipramine. Because of this, it generally is not prudent to taper a heterocyclic antidepressant any faster than 25% of the total dose each week. In practice, some clinicians taper at an even slower rate. In any case, such antidepressant withdrawal-emergent worsening generally responds rapidly to resumption of the antidepressant dosage at the prior effective level. It is not clear if similar tapering strategies are needed for the newer nontricyclic medications. Slow tapering is definitely not required for fluoxetine because of the long elimination half-life of the parent drug and its metabolite, norfluoxetine.

Maintenance Therapy

Maintenance pharmacotherapy should be considered at the end of continuation therapy for most patients with a history of prior episodes of depression. This is particularly true for patients who have suffered episodes of depression within 2 or 3 years prior to the onset of the index episode. For example, in our group's study of highly recurrent unipolar patients, nearly 85% suffered a recurrence within 3 years after the withdrawal of imipramine hydrochloride. In addition to a history of frequent and/or multiple prior episodes of depression, other risk factors for recurrent depression include both early and late onset of depression (i.e., before age 25 or after age 60), chronicity, severity of the index episode, a seasonal

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pattern of mood disturbance, and a family history of affective disorder.

Prescribing a course of maintenance antidepressant therapy involves a careful assessment of the risks of recurrent illness, the expected benefits of continued treatment, and the potential costs of such treatment (in terms of both economics and side effects). Maintenance treatment achieves optimal results when the clinician and patient have established a strong, collaborative alliance. One of the best ways to achieve this is a frank open discussion leading to the *shared* conclusion that the benefits of maintenance treatment outweigh the costs.

The question "Do I need to take antidepressants forever?" comes up rather frequently when patients consider a maintenance treatment plan. Although pharmacotherapists may differ widely in their responses to this question, I do not recommend addressing the patient's concerns by using a biomedical metaphor based on an irreversible disease, such as citing the example of a diabetic who will need to take insulin for the rest of his or her life. In my opinion, such a bleak and potentially demoralizing assessment is not warranted. Rather, the metaphor of controlling hypertension with ongoing medication provides a more optimistic vehicle by which to discuss long-term treatment. Moreover, this model also offers the opportunity to discuss potential reductions of vulnerability through psychosocial and behavioral interventions (i.e., staying within the hypertension metaphor, via weight loss, salt restriction, exercise, and smoking cessation). As in pharmacologic treatment of hypertension, reassessment of the cost/benefit ratio can be performed collaboratively on a periodic basis, such as annually or biannually. On such occasions it is often useful to explore and address certain common but maladaptive assumptions that may be associated with noncompliance or patients' worries about the use of long-term medication ("I don't want to get hooked," "I feel dependent on this stuff," or "For once I'd like to be normal and not have to rely on these drugs to stay well"). Such discussions also may usefully include a spouse, parent, or significant other. In fact, it is our group's experience that the well-meaning but misguided lobbying of family members often provides the impetus for patients' requests to discontinue medication. In our long-term research clinic, we developed a psychoeducational workshop specifically to minimize these familial roadblocks to effective maintenance therapy.

Choice of Maintenance Treatment

Maintenance pharmacotherapy generally consists of the same antidepressant agent(s) that was effective during acute and continuation therapy. Patients typically are seen monthly, and after a period of sustained recovery, some patients may need to be seen every other month or even less frequently. The tricyclics and lithium carbonate have received the most extensive study, and in reviews of earlier research, both modalities have been shown to convey about a twofold or threefold protective effect over 18 to 36 months of maintenance therapy when compared with placebo.

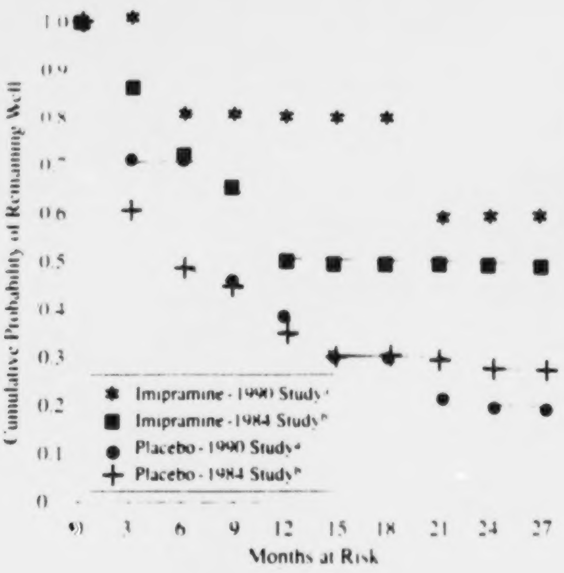
On the basis of available published literature, it could be argued that the tricyclic antidepressants are the treatment of choice for prophylaxis of recurrent unipolar depression. However, this position is mainly due to the tenure of this family of antidepressants (relative to newer agents) and their greater use in the 1960s, 1970s, and 1980s (relative to MAOIs). There is only one published maintenance study directly comparing a TCA with an MAOI. In this placebo-controlled trial, Georgotas et al. found that phenelzine, but not nortriptyline, was effective in preventing recurrent episodes of late-life depression. This unexpected finding requires replication. Other "open label" studies suggest that long-term MAOI treatment achieves a level of prophylaxis comparable to that seen with maintenance TCA therapy (see Thase).

In a meta-analysis of early studies, Davis[54] documented that lithium salts clearly were efficacious in preventing depressive relapses and recurrences. European studies tend to provide the strongest support for the efficacy of long-term lithium prophylaxis of unipolar depression. However, in a well-conducted multicenter American study, unipolar patients randomly assigned to lithium carbonate maintenance treatment had a significantly poorer outcome than patients receiving imipramine hydrochloride, with or without concomitant lithium therapy. Moreover, lithium carbonate therapy was only marginally more effective than placebo in this study. Similarly, in a recent trial conducted in the United Kingdom, the combination of lithium and amitriptyline was found to be no more effective in preventing recurrence in unipolar depression than amitriptyline alone. Therefore, the routine use of lithium salts instead of, or in combination with, antidepressants does not appear well-justified in the maintenance treatment of unipolar depression. However, as will be discussed later, most cases of bipolar depression warrant lithium salts as a "foundation" maintenance therapy, as do some cases of treatment-resistant unipolar depression.

Dosage of Maintenance Pharmacotherapy

Many clinicians were trained to reduce the dosage of antidepressant during long-term treatment, typically to a "maintenance dosage" of about one half that used during acute therapy. Although this practice may have merit in the long-term treatment of schizophrenia, it may not be the most effective approach for prophylaxis of recurrent affective disorders. Specifically, our group has proposed that the 40% to 60% "survival" rates observed most early studies of maintenance pharmacotherapy reflect suboptimal pharmacotherapy and could have been

Figure 3. Cumulative Probability of Remaining Well in Trials of Maintenance Pharmacotherapy Using Reduced and Full Dosages of Imipramine



[a]Full imipramine dosage trial (mean = 216 mg/day): data from reference 51.
[b]Reduced imipramine dosage trial (mean = 137 mg/day): data from reference 60.

improved upon by use of higher (i.e., therapeutic) dosages of medication.[51]

Results from several studies of unipolar depression support this contention. First, in a retrospective examination of cases treated in a university-affiliated mood disorders clinic, Peselow et al.[62] reported that patients who suffered recurrences were maintained on lower dosages of antidepressants than those who remained well. Second, in a study[61] comparing low (75 mg/day) and ultra-low (37.5 mg/day) dosages of maintenance maprotiline hydrochloride, significantly more recurrences occurred in the ultra-low dosage group. Third, an examination of our group's experiences conducting long-term treatment trials in the past 15 years yields similar evidence. As illustrated in Figure 3, the relapse rate of patients reduced to lower dosages of imipramine (i.e., 75 to 150 mg/day; mean dosage = 137 mg/day) in the aforementioned multicentered trial[60] was significantly higher than the rate observed in our group's more recent single-site study (mean dosage = 216 mg/day).[51] Further, because the relapse rates on placebo were virtually identical in the two studies, it can be inferred that the patients participating in these trials were at comparable risk for recurrence.

Although clearly suggestive, such observations warranted prospective confirmation. Data are now available from a recently completed, double-blind study conducted by Frank and associates (Frank EF, Kupfer DJ, Perel JM, et al. 1992. Unpublished data). Twenty patients with highly recurrent unipolar depressions (≥ 4 lifetime episodes) were randomly assigned after continuation therapy to either full-dose (approximate mean dosage = 200 mg/day; N = 10) or half-dose (approximate mean dosage = 100 mg/day; N = 10) maintenance imipramine pharmacotherapy. The recurrence rate in the half-dose group over 36 months was 70%, whereas only 30% of the patients in the full-dose group suffered recurrences. The full-dose maintenance treatment strategy has thus been shown to be significantly more effective than lower-dosage strategies in both retrospective and prospective comparisons.

Side effect concerns. The long-term side effects of conventional tricyclics, monoamine oxidase inhibitors, and lithium carbonate are, of course, one valid reason underlying the use of lower-dosage maintenance strategies.[4,5] Although long-term pharmacotherapy with these agents is tolerated by a majority of patients, ongoing problems with weight gain, dental caries (caused by chronic xerostomia), severe constipation, and sexual dysfunction may complicate maintenance treatment with heterocyclic agents. Further, such adverse experiences may lead to noncompliance, dosage reductions, and/or premature withdrawal of medication.[1,50] Clinical experience suggests comparable problems with weight gain, edema, insomnia, and sexual dysfunction during long-term MAOI therapy.[1,50,64] One study suggests that attrition due to intolerable side effects may be higher during long-term MAOI treatment than observed during maintenance tricyclic therapy.[65] Weight gain, acne, diarrhea, polyuria, tremor, and hypothyroidism have been shown to complicate long-term lithium therapy,[4,7] with the specter of chronic renal interstitial fibrosis lurking in the background.[66] Again, there is a clear need for alternative treatments.

Long-term treatment with the newer antidepressants. Side effect concerns have been a driving force behind the interest in the newer antidepressant agents, including so-called second generation agents (i.e., trazodone, maprotiline, and amoxapine), the selective serotonin reuptake inhibitors (SSRIs) (i.e., fluoxetine and sertraline), and the novel monocyclic antidepressant bupropion. There is no doubt that these agents are effective treatments for depressed outpatients, and they typically convey a significant advantage with respect to daily side effect burden. Several studies indicated that, while effective in preventing relapse and/or recurrence, the second generation agents maprotiline[61,67] and amoxapine[68] do not convey substantial advantages over the tricyclics with respect to the incidence of side effects. By contrast, the combination of efficacy and safety offered by the SSRIs has led to their rapid acceptance as the most common

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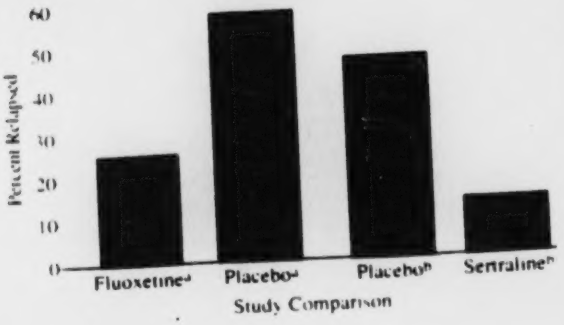
Figure 4. Summary of Relapse/Early Recurrence Rates for Placebo and Selective Serotonin Reuptake Inhibitors



^a Data from reference 69 (24-month study).
^b Data from reference 70 (44-week study).

newly prescribed antidepressants by American psychiatrists. Although extensive data on the long-term efficacy and safety of the SSRIs and bupropion are lacking, results from two controlled studies support the efficacy and tolerability of fluoxetine[68,69] and sertraline[70] during the first year of continuation/maintenance treatment (see Figure 4). Moreover, in the study of Doogan and Caillard,[70] sertraline could not be distinguished from inert placebo during long-term treatment in terms of side effect ratings and attrition rates. Open-label data also support the potential utility of trazodone[71] and bupropion[72] as long-term, preventative treatments.

How Long Should Pharmacotherapy Be Maintained?

There is no single, correct answer to this important question. Unlike continuation pharmacotherapy, which is indicated for virtually all patients and defined by a relatively narrow time frame, maintenance treatment may extend indefinitely.[1,4,50] A general answer would be "for as long as the benefits outweigh the costs." After the first 24 or 36 months of pharmacotherapy, however, empirical data to support this maintenance treatment plan are generally lacking.[1,45] On one hand, many thousands of patients have taken maintenance tricyclic and MAOI antidepressants and/or lithium salts for 10, 15, or even 20 years without markedly adverse side effects. On the other hand, the meta-analysis conducted by Belsher and Costello[28] suggests that the annualized risk of subsequent depressive episodes becomes rather small after 2 years of sustained recovery. Our group[73] recently completed a small but informative study of 20 unipolar patients who experienced 3 illness-free years during maintenance imipramine treatment. These patients subsequently were randomly assigned to either 2 more years of imipramine treatment (mean daily dose = 243 mg/day) or double-blind placebo substitution. The 2-year recurrence rate among 9 placebo-treated patients was 67%, compared with 9% of 11 patients receiving ongoing imipramine treatment ($p < .006$). Although the highly recurrent nature of this sample may bias the placebo group's recurrence rate upward, the clinical implication is clear: even after 3 years of sustained recovery there remains a significant risk of recurrent depression following withdrawal of maintenance pharmacotherapy.

What is the Role of Maintenance Psychotherapy?

Debates over the relative merits of psychotherapeutic and pharmacologic treatments of affective disorders often become polarized around issues of economic and interdisciplinary rivalries. The heterogeneous and biopsychosocial nature of the mood disorders provides ample room for the popular strategy of combining these modalities,[1,28,34,74] i.e., a position supported by a modest amount of empirical evidence from the acute-treatment literature.[74] However, it should be recognized that, at present, strong empirical justification for the routine combination of these forms of therapy as maintenance treatment strategies is lacking.

Only two studies have addressed the long-term impact of interpersonal psychotherapy in the continuation or maintenance phases of treatment.[51,76] In the first study,[76] 150 recently remitted nonbipolar women who had responded to acute pharmacotherapy with amitriptyline were randomly assigned to a 6-month course involving one of the following four strategies: individual interpersonally oriented psychotherapy; placebo pharmacotherapy; maintenance amitriptyline; or the combination of psychotherapy and pharmacotherapy. When compared with the amitriptyline only condition, psychotherapy plus pharmacotherapy showed no greater degree of prophylaxis. Further, the survival rate of the psychotherapy-treated cases withdrawn from amitriptyline was not significantly greater than that of the group treated with only placebo.[76] There was, however, evidence of improved interpersonal functioning in women treated with psychotherapy who maintained euthymia.[77]

In the more recent study, Frank and Kupfer[74] found that a systematized form of maintenance interpersonal psychotherapy (IPT-M),[78] provided on a monthly basis following an initial course of weekly sessions (in combination with pharmacotherapy), was significantly more effective in preventing recurrence than placebo.[47,51] However, IPT-M was found to be significantly less effective than maintenance imipramine pharmacotherapy.[51] Further, patients randomly assigned to receive the combination of IPT-M and imipramine *did not* show significantly superior prophylaxis when compared with those receiving pharmacotherapy alone (see Figure 5).[51]

A subsequent analysis of the therapeutic course of patients treated with IPT-M revealed a significant association between quality of therapeutic relationships and the prophylactic success of maintenance psychotherapy.[79]

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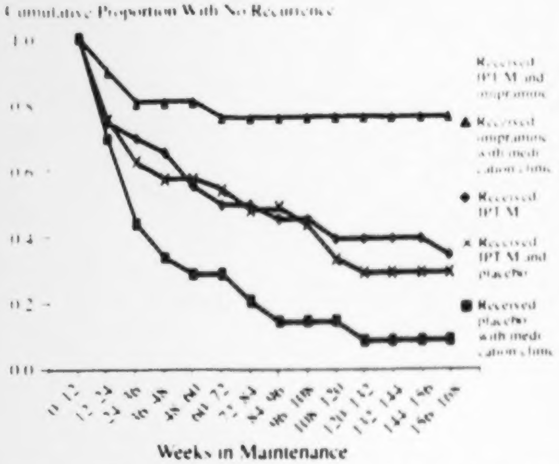
Figure 5. Cumulative Proportion With No Recurrences During Long-Term Treatment With Placebo or Imipramine and Interpersonal Psychotherapy, Singly and in Combination*



*From reference 51, with permission. Abbreviation: IPT-M = maintenance interpersonal psychotherapy.

Those patients who participated in high-quality therapeutic dyads (i.e., as defined by average session scores above the mean on a measure rating therapy adherence) were at significantly lower risk of relapse than the patients whose dyads were below the mean on this measure. Beyond the issue of the technical quality or specificity of therapy, many psychotherapists might argue that the "dosage" of therapy received is suboptimal. A study by Frank and colleagues is just starting in our Depression Prevention Clinic to try to ascertain if more frequent psychotherapeutic contact can enhance the preventative efficacy of maintenance IPT.

The CBT of Beck et al., the other main form of psychotherapy developed for use with depressed patients, has not yet been studied in long-term treatment trials. Nevertheless, results of a number of naturalistic follow-up studies suggest that lower relapse rates tended to be observed in patients treated with CBT over the first 6 to 24 months of follow-up when compared with patients withdrawn from TCAs.[illegible] In one study, the apparent prophylactic effect following successful CBT was comparable to that observed during continuation and maintenance pharmacotherapy.[illegible]

SPECIAL TOPICS

Recurrence During Maintenance Therapy

Controlled and naturalistic studies indicate that between 20% and 70% of patients with recurrent unipolar depression will ultimately suffer recurrences despite being maintained on antidepressant pharmacotherapy.[illegible] In our group's experience, noncompliance and other causes of inadequate blood drug levels are the leading reasons for such episodes.[illegible] Whenever feasible, a prudent first step in the evaluation of a "breakthrough" episode is to obtain a blood drug level. An unexplained reduction in blood level usually points to compliance problems, which warrant prompt psychoeducational and psychotherapeutic interventions.[14] It is imperative to ask patients directly about their medication compliance, and it is also useful to discuss recent changes in the patient's life circumstances in order to identify potential psychosocial correlates of the clinical worsening. On occasion, a patient may admit to decreasing or discontinuing antidepressant medication as a pathologic response to relationship difficulties or other stresses. Such episodes of conflict-related noncompliance are an important factor for concurrent psychotherapy during long-term medication treatment.[illegible]

For the newer agents, upward titration of the dosage may be considered an option in this scenario, particularly because valid blood level determinations are not yet available. However, this strategy does not address the likelihood that noncompliance was related to the recurrence. Moreover, a "routine" strategy to increase dosage in response to a breakthrough episode may lead to increased toxicity if the patient subsequently tries to remedy the problem by improving his or her compliance without telling the attending physician.

It also is important in the evaluation of treatment-emergent episodes to again review what other medications the patient is taking. Although elevations in blood levels also may result from a different type of noncompliance, higher than expected blood levels are more likely to reflect drug interactions and/or changes in hepatic metabolism. This is particularly relevant to the care of patients taking antidepressant drugs that have a therapeutic "window" of efficacy, such as nortriptyline. One common metabolic interaction occurs between inhaled tobacco smoke and tricyclic antidepressants. Smokers typically have a more rapid metabolism of TCAs due to hepatic enzyme induction, which may result in an unexplained increase in drug blood levels following cessation of smoking if the dosage is not reduced accordingly. Other important interactions include elevations of tricyclic levels in patients taking concomitant antidepressant therapy with fluoxetine, antipsychotic therapy with a phenothiazine, or antiulcer therapy with cimetidine.

The concept of neurophysiologic tolerance to the therapeutic effects of antidepressant agents has been proposed to account for some "breakthrough" cases.[illegible] Although this hypothesized effect has been reported for virtually all antidepressants, it should be noted that it is never possible to be certain that the patient's initial response was specifically due to the initiation of pharmacotherapy (vis-à-vis attention/placebo expectancy factors or spontaneous remission). Some clinicians opt to handle this type of breakthrough episode by adding lithium carbonate, whereas others prefer to switch to another antidepressant agent. Still others initially may handle the pharmacotherapy of a breakthrough episode more conservatively, emphasizing identification and resolution of potential stressors via intensified psychotherapy. There are simply no empirical data to guide such decisions. However, it is generally good practice to defer a major switch in the treatment plan for at least 1 or 2 weeks in order to differentiate a minor, stress-related symptom "flurry" from a bona fide recurrent episode.

Patients suffering recurrent episodes despite pharmacotherapy require particularly close follow-up. Such renewed depressive symptomatology despite compliance with medication often is associated with suicidal ideation and/or loss in confidence in the treatment plan related to an understandable degree of demoralization. Further, access to a large "maintenance" supply of tricyclic antidepressants provides a particularly lethal method for use in a suicide attempt.

Maintenance Therapy of Psychotic Depression

Psychotically depressed patients generally have more serious and incapacitating illnesses, with high risks of relapse and suicide during follow-up. Many psychotically depressed patients require treatment with combined antidepressant/antipsychotic regimens. Amoxapine, which has modest antipsychotic potency when used as a monotherapy, also has been shown to be a useful treatment of psychotic depression.

There are essentially no empirical data to guide clinicians' strategies for continuation and maintenance treatment of psychotic depression. Although it is clear that some patients relapse when the neuroleptic is withdrawn from a combined therapy regimen, many clinicians prefer to discontinue the antipsychotic agent as soon as feasible because of the risk of tardive dyskinesia. Moreover, it is not known if amoxapine monotherapy is associated with a lower relative risk of tardive dyskinesia than antipsychotic-antidepressant combinations.

Until more definitive data are available, a strategy for continuation and maintenance treatment of psychotic depression is described below, extrapolated from long-term treatment strategies for severe nonpsychotic depression. Specifically, it is recommended that the antidepressant/antipsychotic combination should be continued for at least 6 months, using the lowest possible dosage of neuroleptic necessary to maintain a sustained remission. Once criteria for recovery have been achieved, the antipsychotic may be slowly tapered over several months, *unless* the patient has previously suffered recurrences on antidepressant medication alone. After discontinuation of the antipsychotic, it may be necessary to increase the antidepressant dosage in order to account for changes in metabolism. Those patients who remain well following neuroleptic withdrawal are then maintained on antidepressant monotherapy for an indefinite time period, using the cost-benefit approach described earlier. Those patients who experience symptomatic exacerbations during withdrawal of the neuroleptic are restabilized using another period of combined continuation therapy. For patients who appear "neuroleptic-dependent," a thorough discussion of the risks of tardive dyskinesia and rationale for ongoing antipsychotic treatment is needed, as are periodic assessments of involuntary movements. The use of the novel antipsychotic clozapine in such cases clearly deserves consideration, particularly when previously unaffected patients begin to manifest signs of tardive dyskinesia.

Maintenance Therapy Following Electroconvulsive Therapy

The risk of relapse is particularly high following electroconvulsive therapy (ECT). Moreover, a successful course of ECT conveys, at best, only questionable protection against subsequent recurrent depressive episodes. These risks are heightened by the current clinical utilization of ECT, which skews the population of treated cases to include an overrepresentation of vulnerabl[illegible] groups, including psychotically depressed, elderly, a[illegible] treatment-resistant patients.

In contemporary practice, virtually all patients receive continuation and maintenance pharmacotherapy following ECT. However, one recent study found that patients who had not responded to an adequate trial of tricyclic antidepressants prior to ECT should not receive the same agent for maintenance therapy. These patients had a high risk of relapse when resumed on these agents for continuation treatment, whereas significantly greater prophylaxis was obtained in those patients who were not treatment-resistant.

Some clinicians use antidepressant/lithium salt combinations for prophylaxis of tricyclic-resistant patients following ECT, whereas others prefer switching to an MAOI or an alternate novel monotherapy. In cases of multiple prior relapses, some clinicians may recommend a sustained course of weekly or biweekly "maintenance" ECT treatments. Despite the large proportion of treatment-resistant cases now referred for treatment with ECT, I have yet to see a patient who has a confirmed history of failure to benefit from *all* available antidepressant options. It is a somewhat curious notion (but nevertheless true) that, in this era of second- and third-generation antidepressants, the TCAs ultimately may be established [illegible] excellent post-ECT maintenance treatments for pati[illegible] who have previously failed to respond to SSRIs or other newer agents.

Maintenance Therapy of Bipolar Depression

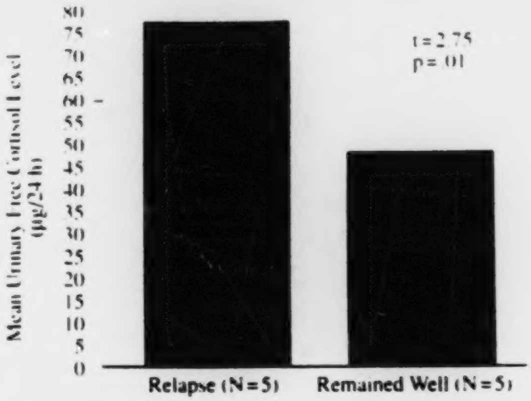
Unlike unipolar depression patients, there is little agreement whether or not bipolar patients should receive sustained prophylactic treatment with antidepressant agents.[illegible] This controversy is due, in part, to concerns about induction of mania and rapid cycling during continuation or maintenance antidepressant pharmacotherapy.[illegible] It is clear that a pattern of rapid cycling can be induced by prescription of antidepressants in selected cases,[illegible] particularly among female patients and those with covert thyroid disease and/or bipolar II subtype. However, it is not clear that continuation antidepressant pharmacotherapy conveys any increased risk for most patients receiving concomitant therapy with a mood stabilizing agent such as lithium carbonate.[illegible] Further, precipitous withdrawal of antidepressants after a short period of acute treatment also may prove to be as implicated in the processes underlying rapid cycling and treatment-induced mania as continued pharmacotherapy.[illegible] Some doubt persists with respect to whether the pattern of rapid cycling is induced by the prescription of antidepressant per se or by an "on again/off again pattern of prescription."[illegible] Nevertheless, most experts agree that use of antidepressants should be minimized once a patient begins to cycle rapidly.[illegible]

Although longer-term antidepressant therapy may not have consistent adverse effects for most patients suffering from bipolar depression, it is unfortunately true that available evidence provides only weak support for its efficacy as a maintenance treatment.[illegible] For example, several contemporary studies have found that the combination of tricyclic antidepressants and lithium carbonate was no more effective in preventing affective recurrences in bipolar disorder than lithium alone.[illegible] Pharmacotherapy with lithium salts (and, for lithium-intolerant or nonresponsive patients, carbamazepine or sodium valproate) thus remains the mainstay of prophylaxis.[illegible] And yet, depressive relapse and recurrence remain significant problems for bipolar patients during long-term monotherapy with these mood stabilizing agents.[illegible] Promising results have been observed with several alternate forms of antidepressant therapy, including fluoxetine,[illegible] bupropion,[illegible] and tranylcypromine,[illegible] either singly or in combination with lithium salts. These preliminary observations warrant more systematic study in larger samples.

Psychobiology of Depressive Vulnerability

Continuation pharmacotherapy may be conceptualized using the metaphor of applying a cast to a broken limb, i.e., the treatment provides an external structure that strengthens or restrains a weakened or unstable system. For patients with multiple relapse or recurrence it must be assumed that the system is inherently unstable, in manner not unlike disunion of a fracture. As reviewed elsewhere, effective antidepressant treatment has been shown to correct inefficiencies in noradrenergic neurotransmission, reverse alterations in cerebral metabolism, suppress aberrant electroencephalographic (EEG) sleep indices, and reduce hyperactive hypothalamic-pituitary-adrenocortical (HPA) function.[104,105] These neurobiological disturbances, which are most pronounced in severe depressive states, provide a means by which the activity of the underlying illness state can be monitored in research studies and, possibly, may be associated with the need for ongoing pharmacotherapy.

Figure 6. Patients Who Relapse After Initially Responding to Inpatient Cognitive Therapy Have Significantly Higher Levels of 24 hr Excretion of Urinary Free Cortisol*



*Data from reference 110

Perhaps the best studied state-dependent correlate of severe depression is hypercortisolism, as reflected by either elevated urinary free cortisol excretion or dexamethasone nonsuppression.[104,105] Although most hypercortisolemic patients show reversal of these abnormalities following effective treatment, a minority of patients show persistent indices of HPA hyperfunction.[104,105] Moreover, higher relapse rates have been documented in patients with persistent hypercortisolism despite continuation pharmacotherapy.[illegible] Our group recently found a similar relationship between elevated urinary free cortisol levels and relapse in unmedicated outpatients treated with an intensive inpatient form of CBT (see Figure 6).[110]

A blunted thyrotropin response following intravenous infusion of thyrotropin-releasing hormone (TRH) also may reflect depressive vulnerability,[illegible] even though this abnormality may be a state-independent (i.e., trait-like) correlate of depression.[illegible] Several EEG sleep correlates of depression similarly have been shown to behave as more stable, trait-like indicators of affective illness, including reduced latency to the onset of the first rapid eye movement sleep period (i.e., reduced REM la-

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tency), decreased percentage of slow wave sleep, and a relatively decreased number of computer-scored delta waves in the first non-REM sleep period (i.e., decreased delta ratio).[104,105] Several recent studies indicate that reduced REM latency[114,115] and decreased delta ratio values[116] predict an increased risk of recurrent depression after withdrawal of continuation pharmacotherapy. These observations, coupled with reports of increased risk of recurrence in persons with family histories of affective disorder,[25] suggest that more stable or persistent vulnerabilities also may serve as indicators of the risk of recurrent depression.

Investigations of the relationship between life stress and the psychobiologic correlates of affective illness provide an alternate approach to understanding depressive vulnerability.[25,104,105,117] It is commonly observed that severe forms of unipolar and bipolar disorders appear to cycle quite autonomously, i.e., without clear-cut environmental provocation.[2-6] Expressed another way, highly recurrent affective disorders may require less in the way of precipitating adversity than first- or second-episode cases.[117] Post[117] proposed that the neurophysiologic model of kindling may extend to affective illness, such that repeated exposures to the neurochemical and neuroendocrine correlates of depression may alter central nervous system structure and/or function. This could account for the marked vulnerability seen in highly recurrent and/or chronic cases,[1-5] as well as the tendency for severity of depression to worsen with repeated episodes.[118] In this regard, Sapolsky[119] has shown in primates that the chronic stress resulting from social subordination alters the HPA responses in a way analogous to those seen in severe recurrent depressions. Gold and colleagues[120] further point out that exposure to environmental stresses during critical periods of mammalian development may subsequently cause altered neuroregulatory and homeostatic responses later in life, when the animals are mature. Finally, normal aging also alters the inhibitory function of hippocampal glucocorticoid receptors such that smaller amounts of perceived stress may provoke sustained or pathologic hypercortisolism.[121] The potential neurobiological ravages of each new episode of severe depression, coupled with altered stress responsivity resulting from early trauma and/or age-related changes, may go a long way toward explaining why some recurrent depressive disorders become autonomous and, at times, intractable illnesses. At present, the best way to prevent the development of intractable affective illness is to prevent the recurrence of an index-treated episode.

SUMMARY

A majority of persons who become clinically depressed will, at some point, suffer another episode. Further, factors such as psychosocial vulnerability and inadequate treatment may lead to relapse, chronicity, and elevated risks of recurrent depression episodes. The interaction of psychosocial and biological vulnerability factors may cause a "kindling" of affective illness, such that each new episode is more autonomous and/or severe. The best strategy to avoid this deteriorative process begins with provision of a vigorous course of acute therapy, resulting in a complete remission. When pertinent, the psychosocial vulnerability factors appear to warrant the combined use of psychotherapy and pharmacotherapy. This is followed by a course of continuation therapy until the patient has achieved a full recovery. Ongoing maintenance therapy, which may extend for years, is indicated in cases of recurrent depression and for those with heightened vulnerability. Full dosages of antidepressants are recommended for use in continuation and maintenance pharmacotherapy and more complex regimens are often needed in cases of refractory, psychotic, and bipolar depression. The newer antidepressant agents have great promise as long-term treatments by reducing the side effects that may lead to noncompliance and/or premature termination of therapy.

Drug names: amitriptyline (Elavil and others), amoxapine (Asendin), bupropion (Wellbutrin), carbamazepine (Tegretol and others), cimetidine (Tagamet), clomipramine (Anafranil), clozapine (Clozaril), fluoxetine (Prozac), imipramine (Tofranil and others), maprotiline (Ludiomil), nortriptyline (Pamelor and others), phenelzine (Nardil), sertraline (Zoloft), tranylcypromine (Parnate), trazodone (Desyrel and others).

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ANXIETY DISORDERS

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ANXIETY DISORDERS

Panic Disorder with Agoraphobia

Panic Disorder without Agoraphobia

Agoraphobia without history of Panic Disorder

Social Phobia

Simple Phobia

Obsessive Compulsive Disorder

Post-traumatic Stress Disorder

Generalized Anxiety Disorder

1. PHOBIA - an overwhelming fear of a specific
   object or event
   no real danger
   ends when object/event is removed
2. PANIC ATTACK - an overwhelming fear not
   related to a specific event/situation/
   object
   begins and ends abruptly
3. ANXIETY - a persistent, generalized tension -
   uneasiness not triggered by an external
   event

ANXIETY DISORDERS

Key Features

ANXIETY	**AVOIDANCE BEHAVIOR**
Panic Disorder	Panic Disorder with Agoraphobia
OCD	OCD
GAD	Phobic Disorders

PANIC DISORDERS

- recurrent panic attacks
- at least 4 characteristic associated symptoms
- lasts minutes to hours
- unexpected nature not triggered by situations in which individual is the focus of attention (social phobia)
- sudden onset
- associated symptoms

PANIC DISORDER WITH AGORAPHOBIA

fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available in the event of a panic attack

SOCIAL PHOBIA

- persistent fear in one or more situations
- person exposed to scrutiny
  may be event limited
- avoidant behavior interferes with occupational functioning
  or usual social activities

SIMPLE PHOBIA

- persistent fear of circumscribed
  stimulus "specific"
- immediate anxiety response
- marked anticipatory anxiety

OBSESSIVE COMPULSIVE DISORDER
(O C D)

recurrent obsessions or compulsions

severity -- marked distress

interferes significantly with routines, occupational functioning, usual social activities

OBSESSIONS - ideas, thoughts, impulses, urges

COMPULSIONS - repetitive, purposeful, and intentional behaviors performed in response to an obsession, according to certain rules or in stero-typed fashion

- recognition that behavior is unreasonable
- efforts to resist accompanied by increased anxiety

POST-TRAUMATIC STRESS DISORDER

event outside range of usual human experience

- reexperience event
- avoidance of stimuli associated with the event
- numbing of general responsiveness (emotional anesthesia)
- increased arousal
- greater than one month duration
- difficulty with sleep, nightmares, hypervigilance, exaggerated startle response

GENERALIZED ANXIETY DISORDER
(G A D)

unrealistic or excessive anxiety regarding two or more life

circumstances six months or longer

symptoms:

- motor tension
- autonomic hyperactivity
- vigilance and scanning

Comparison of Benzodiazepine Antianxiety Drugs

GENERIC DRUG	TRADE NAME	ADULT DOSE[1]	HALF-LIFE	ABSORPTION RAPIDITY
Alprazolam	Xanax	0.5 mg, TID	short	intermediate
Chlordiazepoxide	Librium and others	10 mg, TID	long	intermediate
Clorazepate	Tranxene	7.5 mg TID	long	fast[2]
Diazepam	Valium	5 mg, TID	long	very fast
Flurazepam[3]	Dalmene	15-130 mg, hs	long	fast
Halazepam	Paxipam	20 mg	long	intermediate
Lorazepam	Ativan	1 mg, BID	short	intermediate
Oxazepam	Serax	10 mg, TID	short	slower
Prazepam	Centrax Verstran	10 mg, BID	long	slowest[2]
Temazepam[3]	Restoril	30 mg, hs	short	slow
Triazolam[3]	Halcion	0.25-0.5 mg, hs	short	very fast

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[1] Geriatric patients should receive 30-50% less than the usual adult dose.

[2] These drugs are pro drugs for desmethyldiazepam: the parent drug is rapidly converted to the active metabolite.

[3] Sedative/hypnotic agent used to increase the onset and duration of sleep.

5

Anxiety

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FROM:
The Practioner's Guide to Psychoactive Drugs.
Alan J. Gelenberg, Ellen L. Bassuk, Steven C.
Schoonover, eds. 3rd ed. New York: Plenum
Medical Book Co., 1991.

I. INTRODUCTION

A. Anxiety: A Definition

Anxiety is a universal human response to routine stress and emotional conflict that is experienced both psychologically and physiologically. It is important to distinguish "normal" anxiety from "pathological" anxiety or **anxiety disorder.** Pathological anxiety may be distinguished from normal by its autonomy, intensity, duration, or associated behavior. When "autonomous," anxiety appears to have a "life of its own," with minimal basis in identifiable environmental stimuli. The "intensity" of symptomatic distress for pathological anxiety frequently exceeds the patient's capacity to bear the discomfort; the experience, therefore, is unlikely to engender a healthy, adaptive response. When symptoms recur or persist over time, the duration of anxious suffering will typically indicate pathology. Finally, pathological anxiety may trigger such stereotyped behavioral responses as avoidance or lifestyle constriction.

Similar to fear, anxiety symptoms are generally of two types: the first is a sustained state of increased arousal, concern, worry, and vigilance resembling the uncertainty, caution, and alerted stance of an individual passing through a potentially dangerous setting, like a dark, deserted alleyway; the second type resembles the state of alarm, terror, or panic that would be triggered by an actual sudden life threat, as if an assailant had suddenly emerged from that same alleyway. The former, analogous to generalized or anticipatory anxiety, does not appear to be jus milder variant of the latter, which resembles panic attacks. Panic attacks themse

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vary in intensity and symptoms and include mild and limited symptom attacks as well as major attacks. Pharmacological and familial studies suggest a clinically relevant distinction between these two anxiety states.

B. Symptoms

Anxiety is experienced cognitively, affectively, physically, and behaviorally.

1. Cognitive

The cognitive experience of anxiety typically involves apprehensive, vigilant, and pessimistic appraisal of circumstances. For a panic attack, the cognitive component is one of catastrophic thinking, with appraisal of the attack as a life-threatening ailment or one likely to lead to insanity or great embarrassment. With generalized or anticipatory anxiety, the cognitive response is more one of rumination, worry, and overconcern.

2. Affective

Anxiety is a dysphoric state of emotional arousal that frequently drives the sufferer to seek relief. Many who have suffered panic attacks, for example, describe the event as one of the most unpleasant experiences of their life; they would go to any length to avoid a subsequent similar experience.

3. Physical

The intensity of physical symptoms of anxiety varies, as does the primary somatic locus of anxious suffering among individuals. Typical symptoms are cardiac (palpitations, tachycardia, chest tightness), respiratory (hyperventilation, dyspnea, shortness of breath), neurological (dizziness, paresthesias, tremulousness), or gastrointestinal (nausea, intestinal cramping, diarrhea). Other autonomic symptoms frequently occur (hot or cold flashes, diaphoresis, dry mouth).

4. Behavioral

Possible behavioral concomitants of anxiety include avoidance, flight, a freeze response, help-seeking behavior, or other maladaptive attempts to diminish the experience, such as excessively dependent behavior or rituals.

II. MODELS

As innate responses for protecting the human organism and enhancing survival, panic and vigilance are normal in the face of threatening stimuli. As "anxiety" or psychopathological symptoms, other factors besides actual physical threat must be implicated as "triggers" or cause. Of several explanatory models, the *biological* places emphasis on the wiring and juices of the central nervous system, the *psychodynamic* on meanings and memories, and the *behavioral* on learning and behavior.

A. Biological

Recent animal and neuronal receptor studies emphasize two central systems as being principally involved in fear and pathological anxiety.[1,2] One critical component involves central noradrenergic mechanisms, with particular importance placed on the locus ceruleus (LC), a small retropontine structure that is the primary central nervous system (CNS) source of the neuromodulator norepinephrine. When this nucleus is stimulated in primates, for example, an acute fear response can usually be elicited with distress vocalizations, fear behaviors, and flight. Alternatively, destruction of the LC may lead to abnormal complacency in the face of threat. Biochemical perturbations that increase LC firing elicit anxious responses in animal and man that are blocked by agents that decrease LC firing, some of which are in clinical use as antipanic agents.

A second system involves "benzodiazepine receptors" with particularly relevant concentrations in limbic system structures, especially the septohippocampal areas. One role of the limbic system is to "scan" environmental inputs for life-supporting and threatening cues and to monitor internal or bodily sensations. Vigilance (or its psychopathological equivalent, generalized anxiety) may reflect limbic system arousal. Benzodiazepine receptors in high concentration in relevant limbic system structures may play a role in modulating limbic alert, arousal, and behavioral inhibition by increased binding of the inhibitory neurotransmitter γ-aminobutyric acid (GABA). As one might expect, there are neuronal connections between the LC and the limbic system that coordinate among surveillance, alert, and alarm. Although it is unlikely that any one system or substance is the source or cause of anxiety, the discovery of neuronal receptors for which benzodiazepines have particularly high affinity suggests the existence of ligands that may regulate the experience of anxiety as either endogenous anxiolytics or anxiogens. The fact that neuronal connections and neurotransmitters mediate emotional experience, however, does not of itself minimize the importance of nonpharmacological therapies for anxiety, which also may ultimately act by mobilizing these endogenous anxiety-regulating factors.

Other important clues to a biological basis of anxiety[3] include the observed familial and probably genetic transmission of disorder, the apparently unique sensitivity of patients with panic disorder to certain physiological provocations (e.g., lactate, CO_2), asymmetric blood flow in limbic structures on positron emission tomography (PET) scans of panic patients, and temperamental differences in very young children of patients with anxiety disorder.

If anxiety proneness has a biological basis, one would assume evolution had a reason to select for this characteristic. The anxious individual may have been important to the survival of the larger group by serving as a sentinel, being more alert to danger and more concerned with situations posing threat such as places of restricted escape. Further, many normative "anxious" responses are necessary for survival, such as separation anxiety. The reaction to acute separation in infant primates, for example, takes a form analogous to that of a panic attack, with intense arousal, distress, and care-seeking behavior. The sense of terror experienced by the infant on separation from the mother may be the prototype panic attack, which is reactivated in later life as the consequences of earlier failures at separation and individuation or of early trauma or in those genetically predisposed.

The simplest model for panic and anxiety may be that fear and anxiety are protective and that any good security system must include a surveillance, alarm, and help-seeking mechanism. Further, as anyone with a home security system knows, otherwise well-designed systems frequently have "bugs" and tend to "false alarm" or are triggered by ordinary events because of an excessively sensitive threshold. The problem remains, however, to find either the "bug" or the mechanism to regulate downward the sensitivity to inappropriate activation.

B. Behavioral

Behavioral understanding of anxiety disorder antecedents focuses on learning. Anxiety symptoms or avoidant behavior become associated with benign settings or objects as a result of generalization from earlier traumatic experiences. For example, a child ridiculed by peers because of a mistake during "show and tell" pairs embarrassment and shame with speaking before groups and thereafter manifests anticipatory anxiety and avoidance of public speaking. Self-defeating cognitive "habits" sustain the syndrome with unrealistic catastrophic thinking "expecting the worst." For panic disorder, misinterpretation of bodily stimuli with exaggerated cognitive and behavioral responses also serves to maintain the response. In this model, anxiety occurs when an individual encounters a signal that "predicts" a painful or feared event. Thus, learning theory presumes some real or perceived prior traumatic experience to condition the anxious response.

C. Psychodynamic

Psychoanalysts view anxiety as a manifestation of intrapsychic conflict and describe a continuum of responses. Secondary anxiety signals the ego to mobilize defenses to deal with a stress or conflict. "The anxiety acts as a warning that danger is impending; but the danger is one that the individual is capable of coping with; it is not yet overwhelming or inevitable."[4] Psychoanalysts also have described how anxiety is central to symptom formation and the development of the neuroses (i.e., obsessive compulsive, phobic, etc.). The symptoms

are the end product of the mixture of elements from both an unconscious impulse and the

> ego defenses directed against it. The symptoms are a compromise formation, the result . . . of vectors of forces showing the summated effects of all the elements.[4]

For example, a ladylike and very proper middle-aged woman little given to displays of emotion—and certainly not anger—becomes manifestly anxious when she is alone with her husband. The clinician learns that the symptoms started after the woman learned of her husband's recent infidelity. She is brimming with a sense of outrage toward her husband, but these feelings are intolerable to her. When they threaten to surface, she becomes overtly anxious.

More recent psychodynamic observations, emphasizing object relations, point to the role of internalized objects and their critical function in maintaining affective stability under stress. An adequate developmental experience typically generates internalized objects (introjects) that provide a soothing function, regulating the individual's internal milieu, in the face of distress; the absence of these internal regulators allows the organism to fragment and to experience anxiety in various situations.

Phobic disorders whose sufferers may experience panic, anticipatory, or no anxiety symptoms at all (depending on the success of avoidance behavior) serve to illustrate the differing models. The biological view would recognize the stereotyped nature of phobias, that most objects and situations in everyday life that truly threaten us are rarely selected as phobic stimuli. Children, for example, proceed normally through various developmental phobias (stranger, separation, darkness, etc.), but rarely become phobic of objects and situations that are associated with danger (e.g., electric outlets, roads). Further, most phobic stimuli (e.g., snakes, spiders, close spaces) have meaning in the context of biological preparedness[5] and were presumably selected for by evolution. Psychodynamic observations underscore the use of defense mechanisms such as displacement and the contribution of meanings and symbolic representations of phobic objects and situations. Learning theory, on the other hand, would predict some real or perceived prior traumatic experience with the object or situation. As with most human experience, anxiety rarely can be reduced to one explanatory framework. Clinical observation and research indicate contributing roles for all three models as determinants of behavior and as guides to therapeutic strategies. It is likely that an inherited "anxiety proneness" renders the development of an anxiety disorder more likely, but the onset, course, and shape of the disorder are greatly influenced by development, life events, and relationships.

III. DIFFERENTIAL DIAGNOSIS

Most patients with anxiety symptoms are initially evaluated by a primary care physician, internist, cardiologist, or neurologist for various somatic complaints. Given the predominance of physical symptoms in the experience of anxiety, the differential diagnosis of anxiety symptoms is complicated. Anxiety may be a **consequence** of a medical illness. An anxiety disorder (e.g., panic) may have been **triggered** by a medical illness (e.g., hyperthyroidism) but continue on its own after the inciting disorder is treated. Anxiety may be **associated** or linked with certain medical conditions (e.g., panic disorder with mitral valve prolapse, peptic ulcer disease, irritable bowel, hypertension). Anxiety may **mimic** a variety of medical ailments or, in turn, be mimicked by them. Thus, standard medical procedures, including history, physical, and laboratory examination, are indicated in evaluating a patient with anxietylike symptoms. Given the frequency of coexisting medical problems in psychiatric patients, physical symptoms should not be presumed to reflect anxiety. Because anxietylike symptoms accompany most psychopathological states and many organic problems, the differential diagnosis of anxiety is extensive.

A. Medical

A list of all possible organic causes of anxiety could constitute the index of a medical textbook. Endocrine disorders, such as hyperthyroidism, may reproduce severe anxiety symptoms. Similarly, hypoglycemia, whether caused by an insulinoma or by exogenously administered insulin, can result in anxietylike symptoms, as can secreting tumors such as carcinoid and pheochromocytoma. Patients with various neurological abnormalities—including encephalopathies of diverse etiologies, postconcussion syndrome, and seizure disorders—may report anxiety. Others with severe pulmonary disease and hypoxia also report anxietylike symptoms. Excesses of stimulant drugs (including caffeine) and withdrawal from sedative drugs (including alcohol) can be culprits as well.

It would be impossible to memorize all the possible physical causes of anxiety, and it would be a useless exercise to sit before an anxious patient with a checklist. Rather, the clinician should maintain a high index of suspicion and complete a thorough assessment. When taking a history, inquire about past and present medical illnesses and medications, other treatments, and doctors consulted. Inquire also about the use of over-the-counter drugs as well as "recreational" substances. Hallucinogens, for example, may precipitate a "bad trip" or panic attack. Always ask about alcohol and estimate the amount of caffeine consumption.

Complete a careful review of systems. Although the presence of certain symptoms may not have emerged initially when taking a history from an anxious patient, the systems review may reveal a pattern—such as skin and hair changes, heat intolerance, and weight loss (possible hyperthyroidism)—that can suggest further diagnostic evaluation.

The clinician should complete a routine physical examination with specific attention to areas highlighted by the history. Laboratory tests can be ordered on the basis of findings from the history and physical examination and anticipated medication therapy.

B. Psychiatric

Anxiety accompanies most psychiatric disorders. Patients with schizophrenia, other psychoses, affective disorders, borderline states, and personality disturbances may present with severe anxiety. Before prescribing an antianxiety drug, the clinician should complete a thorough evaluation. Psychoses, affective disorders, personality disturbances, and organic brain syndromes should be considered in the differential diagnosis of anxiety. Once the clinician determines the diagnosis, the general rule is to treat the primary disorder specifically—antipsychotic drugs for schizophrenia, antidepressants for depression, antianxiety treatments for generalized anxiety disorders, etc. On the other hand, it is important to recall that psychiatric disorders may coexist; an anxiety disorder may be comorbid with other axis I psychiatric syndromes listed in the third revised edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IIIR). Among the most difficult psychiatric differential diagnoses is the differentiation of a DSM-IIIR axis I disorder such as an anxiety disorder from an axis II diagnosis in a patient with substantial underlying character pathology such as an individual with avoidant or borderline personality. In the latter case, the individual may describe himself as anxious or depressed when the internal state is more accurately one of emptiness, aloneness, boredom, or fragmentation as a consequence of interpersonal upheavals. Although the presence of an axis II disorder does not exclude treatment of anxiety symptoms, it is important to recognize when character pathology contributes to ongoing symptomatic distress.

IV. ANXIETY DISORDERS

Current nomenclature identifies nine specific subtypes of anxiety disorders: panic disorder with agoraphobia, panic disorder without agoraphobia, agoraphobia without history of panic disorder, social phobia, simple phobia, obsessive–compulsive disorder, posttraumatic stress disorder, generalized anxiety disorder, and anxiety disorder not otherwise specified. Anxiety disorders are the most common form of psychiatric illness in this country, with 15–20% of the population having experienced one of these conditions at some time in their lives.

A. Panic Disorder

Patients with this diagnosis have experienced at least one unexpected panic attack and have either experienced four panic attacks in a 4-week period in their life or one panic attack followed by at least a month of sustained fear of having a subsequent attack. The features of a panic attack include the experience of at least four of the symptoms listed in Table 1 developing suddenly or within 10 min of the onset of the first symptom noticed.

A panic attack is an intensely distressing experience, usually lasting a few to several minutes, with fairly stereotyped physical, cognitive, and behavioral components. Patients with panic disorder may experience these attacks intermittently or in clusters and may develop a number of complications, including persistent anxiousness, phobic avoidance, depression, and alcoholism or other drug overuse.

The physical symptoms of a panic attack include cardiac, respiratory, neu-

TABLE 1. Symptoms of Panic Attacks

1. Shortness of breath (dyspnea) or smothering sensations
2. Dizziness, unsteady feelings, or faintness
3. Palpitations or accelerated heart rate (tachycardia)
4. Trembling or shaking
5. Sweating
6. Choking
7. Nausea or abdominal distress
8. Depersonalization
9. Numbness or tingling sensations (paresthesias)
10. Flushes (hot flashes) or chills
11. Chest pain or discomfort
12. Fear of dying
13. Fear of going crazy or of doing something uncontrolled

rological, gastrointestinal, and other reactions. Cognitively, the patient feels a sense of terror or fear of losing control, dying, or going crazy. Behaviorally, the patient often flees from the setting in which the attack is experienced to a safe, secure, or familiar place or person. Help-seeking behavior is characteristic of a person having panic disorder.

The patient may vividly remember the initial or "herald" attack, which appears in some cases to "turn on" the disorder. Although this first spell is often unexpected ("out of the blue") and intense, later attacks may be either spontaneous and unexpected or preceded by a buildup of anticipatory anxiety. The latter type, called a situational attack, occurs in settings where the patients might sense being at risk for panic or the site of prior attacks, such as a crowded room or stores. Major attacks involve four or more of the symptoms in Table 1. Episodes involving fewer symptoms are considered "limited symptom" attacks.

The typical onset of panic disorder is in early adult life. The illness afflicts women two to three times more often than men. Adults with panic disorder (in particular, those who develop agoraphobia) frequently have a childhood history of separation anxiety symptoms,[6] particularly "school phobia." The disorder is clearly familial and may have a genetic basis.[7]

The onset of the disorder typically follows a major life event (such as a loss, threat of a loss, or other upheavals in work or home situations) or a physiological event such as medical illness (e.g., hyperthyroidism or vertigo) or drug use (e.g., marijuana or cocaine). However, a patient whose herald attack seems to be triggered by the use of cocaine, for example, may continue to have persistent or recurrent symptoms without further drug use. In light of the impressive paroxysmal physical symptoms of a panic attack, most sufferers ascribe the experience to a physical cause and seek evaluation and treatment initially from a nonpsychiatric physician. If the syndrome progresses without proper diagnosis, hypochondriacal behavior may result, followed by demoralization if relief is not obtained.

A panic attack, like an endogenous "false alarm," appears to turn on a state of vigilance or "postpanic" anxiety that resembles generalized anxiety disorder. Between attacks, patients may remain symptomatic with a constant, low-level, anticipatory anxiety that may crescendo into full-blown panic in certain situations, sometimes unexpected. In this state of vigilance, the patient may develop mild or extensive phobic avoidance, usually of travel or places of restricted escape. This behavior may begin immediately following the onset of attacks, after a number of attacks, or never at all. In some cases, phobic avoidance evolves as a progressive constriction, and the patient increasingly avoids a variety of settings, in particular those where attacks have occurred. Thus, agoraphobia frequently occurs as a complication of panic attacks.

The demoralization that accompanies the sustained distress and progressive disability of panic disorder may extend to a major depressive episode with characteristic signs and symptoms. The relationship between panic and depression, however, is a complicated one. Although some patients manifest no depressive symptoms, for others, it is unclear which disorder is primary when the onset of symptoms is concurrent.

Alcohol use can temporarily tame the distress of panic disorder, but the patient soon experiences rebound symptoms, setting the stage for alcohol overuse. Thus, it is not surprising that more than 10% of adult alcoholics may meet criteria for a diagnosis of panic disorder.

The mortality rate of patients with panic disorder may be higher than that of others. Data suggest that there is increased premature mortality from suicide and, for men, from cardiovascular illness.[8] Mitral valve prolapse is also diagnosed much more frequently in panic patients than in either the normal population or patients with generalized anxiety disorder.

Although there are a number of treatment strategies, including pharmacological and behavioral interventions, that can minimize or prevent the symptoms and complications of this disorder, many patients suffer residual symptoms or go many years with their disorder before coming to treatment. Epidemiologic studies suggest that panic disorder and agoraphobia occur in as much as 3% to 6% of the population.

B. Phobic Disorders

There are three general categories of phobic disorders: agoraphobia, social phobia, and simple phobia. **Agoraphobia** is the fear of settings or places of restricted escape, where help might not be available in the event of an emergency, as with a panic attack. Patients suffer travel restrictions and may endure a variety of agoraphobic situations (such as crowds, restaurants, stores, bridges, tunnels, airplanes, or restricted-access highways) with considerable distress or may remain homebound or unable to travel without a companion. Some patients suffer agoraphobia without a clear history of typical panic attacks.

Social phobics experience anxious distress in situations where the patient is the focus of scrutiny by others and fears humiliation or embarrassment. A common circumscribed social phobia is stage fright and fear of public speaking. Other examples include the inability to sign one's name in public or to use public lavatories. Social phobic anxiety may resemble the lower-grade, "generalized" variety or be experienced with the intensity of a panic attack. Social phobia is distinguished from normal anxiety, in part, by the extent of avoidance or social and occupational limitation. Social phobia may also be global with generalized anxiety or panic symptoms in any social setting, whenever the sufferer is in the presence of others, with relative relief available only when alone or with very familiar people.

Social phobias have a 6-month prevalence rate of about 1.5%. They typically have their onset in late adolescence and afflict men and women in roughly equal numbers. This disorder is generally considered underdiagnosed and undertreated. There may be considerable overlap in the presentation of social phobia and panic disorder. Although patients with either disorder may avoid or need to flee from meetings or other social gatherings, social phobics are generally more comfortable when they are alone, in contrast to patients with panic disorder. Similar to panic disorder and agoraphobia, social phobia is frequently complicated by alcohol overuse.

Simple phobias are the irrational fear of and need to avoid specific objects or settings, such as insects or animals, or specific situations (e.g., airplanes, heights). If the object or situation is encountered, the individual suffers intense anxiety that may reach the level of panic.

C. Generalized Anxiety Disorder

In the past, patients who suffered anxiety, whether of the generalized or panic form, had been termed "anxiety neurotics," but observations of patient's responses to drug treatments initiated a "pharmacological dissection" of anxiety disorders. Patients who suffered panic attacks, agoraphobia, or "phobic anxiety states" showed preferential responses to medications that were not "anxiolytic" *per se* (e.g., certain tricyclic and monoamine oxidase inhibitor antidepressants). Standard anxiolytic medications such as benzodiazepines were relatively ineffective in preventing panic attacks but were useful in controlling other forms of generalized anxiety.

Generalized anxiety disorder is diagnosed if the patient has suffered from persistent anxiety for 6 months or more. These episodes are manifested by unrealistic or excessive worry (not related to having a panic attack) and by various symptoms such as motor tension, autonomic hyperactivity, as well as vigilance and scanning behavior that are unrelated to any specific medical or organic cause.

Although generalized anxiety may represent the most prevalent form of anxiety symptoms, its actual prevalence as opposed to reactive anxiety symptoms resulting from transient stressful life situations is unknown. As described (see Section III), anxiousness may be featured in a number of medical and psychiatric conditions; for example, persisting and severe anxiousness may be the presenting symptom of a major depressive disorder. Selection of treatments for persistent anxiety without panic attacks is also controversial. Stress management techniques, other cognitive and behavioral interventions, and various psychotherapeutic interventions may be useful in dealing with relationships and life situations that exacerbate persisting anxiety. On the other hand, substantial numbers of patients with persistent anxiety may obtain long-lasting relief and improvement in function from pharmacotherapy with traditional anxiolytics, antidepressants, and newer antianxiety agents. In lieu of maintenance treatment, short-term pharmacotherapy may help deal with the peaks of stressful anxiety.

D. Other DSM-III Adult Anxiety Disorders

1. Obsessive Compulsive Disorder

Patients with obsessive compulsive disorder (OCD) suffer (1) recurrent unwanted and senseless thoughts that are distressing and intrusive but are unable to be suppressed (obsessions) or (2) compulsions, the need to repeat certain behaviors or rituals in a stereotyped fashion to avoid or diminish intense anxiety.

Although many OCD patients suffer from persistent anxiety symptoms or panic attacks, particularly when confronted with triggers for obsessional rumination or when restrained from carrying out compulsive rituals, the inclusion of OCD among anxiety disorders may not be a good fit for many OCD sufferers. Indeed, OCD may have several forms, including compulsive washing or checking, fears of contamination, primary obsessional slowness, and religious or bizarre ritual behaviors. Obsessive compulsive disorder is frequently an exceptionally disabling syndrome, but, for diagnosis, other causes for obsessive thoughts such as bulimia (with food obsessions) or psychosis must be considered. Depression may also exist with OCD symptoms. Because of the bizarre nature of some obsessions, many patients with the disorder are frequently misdiagnosed as having schizophrenia. The 6-month prevalence rate of OCD is between 1% and 2%. The onset of OCD is generally before the age of 25. As with other disorders, proposed etiologies include psychodynamic, neurochemical (e.g., serotonin dysfunction), neurological (e.g., basal ganglia dysfunction), and behavioral or learning models.[9] There is only a partial overlap between OCD and compulsive personality disorder; OCD also aggregates in families of sufferers of such other disorders as tics and Tourette's syndrome.

2. Posttraumatic Stress Disorder

Patients with this condition may manifest symptoms resembling other anxiety disorders such as panic attacks, but the disorder begins at the time of experiencing or witnessing a life-threatening, violent, or other catastrophic event. Subsequently, the patient reexperiences the traumatic event in vivid memories, recurrent dreams, or other experiences (such as flashbacks). Anxiety symptoms, the tendency to startle easily, sleep dysfunction, and the need to avoid stimuli reminiscent of the original event, all characterize this syndrome.

The actual prevalence of posttraumatic stress disorder (PTSD) is uncertain, but it is estimated that 1% of the general population suffers from it. Of course, this disorder is more prevalent in populations exposed to trauma such as civilians after attack and particularly in wounded Vietnam veterans. PTSD patients have been described as suffering enduring vigilance for and sensitivity to threat with excessive alertness and overreactivity to stimuli. Like panic patients, they manifest increased autonomic arousal, and those who go on to suffer PTSD after trauma may have had more frequent childhood history of behavioral problems as well.

3. Adjustment Disorder with Anxious Mood

This category, although not a DSM-IIIR diagnosis, serves to describe the great number of patients who experience transient periods of pathological anxiety associated with interpersonal, occupational, or other upheavals in their lives. Symptoms are generally time-limited but may achieve sufficient intensity to require treatment.

V. ANTIANXIETY AGENTS

The various anxiety syndromes are mainly treated with two general classes of medication: **antidepressants** (chiefly tricyclic antidepressants and monoamine oxidase inhibitors) and various **antianxiety agents,** most often the **benzodiazepines.** The antidepressant medications are discussed in detail in Chapter 2. The following section focuses primarily on the benzodiazepines. Other agents less commonly used to medicate anxiety are discussed at the end of this section. (See Table 4 and Section VI for a clinical discussion of how these drugs are used to medicate the subtypes of anxiety disorders.)

A. Benzodiazepines

The popularity of this class of antianxiety drugs has generated such articles as "The Benzodiazepine Bonanza" and "Valiumania." From 1964 through 1973, the number of antianxiety drug prescriptions filled in United States drug stores increased dramatically. Most were for the benzodiazepines chlordiazepoxide (Librium® and others) and diazepam (Valium® and others). This trend did reverse, possibly because of adverse publicity among physicians and the lay public. Even with declining general use, over 60 million prescriptions for benzodiazepines were filled in the United States in 1979.[10] Fifteen percent of respondents to one U.S. survey reported using antianxiety agents in the 1970s—a figure comparable to that reported for other developed countries.[11]

Chlordiazepoxide, the first benzodiazepine antianxiety agent synthesized, was marketed in 1960. Three years afterwards, diazepam was introduced and rapidly became the most widely prescribed drug in the world. The popularity of these agents has spawned a number of chemical siblings.

In the following sections, we discuss the eight benzodiazepine drugs currently labeled for antianxiety use in the United States: chlordiazepoxide, clorazepate (Tranxene® and others), diazepam, lorazepam (Ativan® and others), oxazepam (Serax® and others), prazepam (Centrax® and others), halazepam (Paxipam®), and alprazolam (Xanax®). Two other benzodiazepines, flurazepam (Dalmane® and others) and temazepam (Restoril® and others), are marketed for insomnia. Clonazepam (Klonopin®), widely used for treating panic disorder, is labeled for the treatment of epilepsy. The labeled indication for benzodiazepine use (e.g., anxiety versus insomnia) probably has more to do with marketing decisions than with unique pharmacological profiles of the agents.

Benzodiazepines, as noted earlier, are the most widely prescribed antianxiety agents in the world. In fact, they are the most widely prescribed drugs of any type. Their popularity is generally deserved. Clinically, they are highly effective for alleviating acute anxiety, and, in most cases, they probably retain relative efficacy over time. Toxicologically, they are remarkably safe in situations of overdose, and their overall record of safety is unparalleled. Although they are by no means perfect (indeed, much of this chapter is devoted to caveats about their use), benzodiazepine drugs represent a definite step forward in the pharmacological treatment of anxiety.

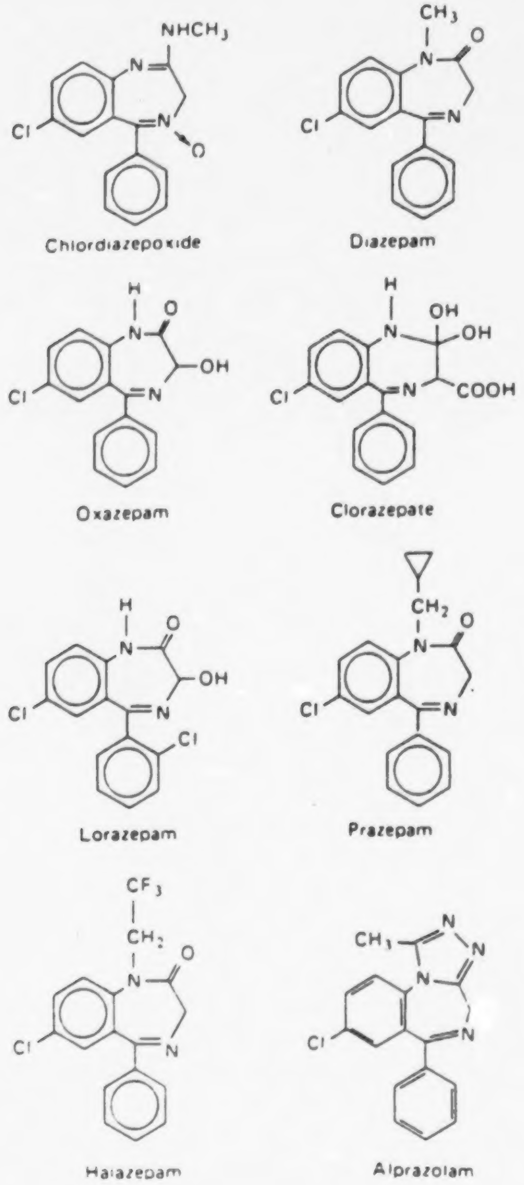
1. Chemistry

Molecular structures of the eight benzodiazepines currently labeled for anxiolytic use are shown in Fig. 1. There are several subtypes of benzodiazepines with some differences in their pharmacology (see Table 2). Diazepam is a prototype of the 2-ketobenzodiazepines, whose other members include desmethyldiazepam (the active agent during administration of clorazepate, prazepam, and halazepam). These drugs are all biotransformed by hepatic oxidative reactions and have long elimination half-lives.

Oxazepam, lorazepam, and the hypnotic temazepam are 3-OH benzodiazepines. They are metabolized by conjugation and have short to intermediate half-lives. Alprazolam is a triazolobenzodiazepine, which also undergoes oxidation in the liver, but whose rate of elimination is considerably more rapid than that of the 2-ketobenzodiazepines. Chlordiazepoxide is chemically distinct but pharmacologically similar to the 2-keto drugs. Clonazepam is a 7-nitrobenzodiazepine, which has a distinct biotransformation.

2. Pharmacological Effects and Mechanism of Action

Benzodiazepines reduce the effects of anxietylike behavior in animals. For example, in a commonly employed behavioral paradigm, the presence of a light in a rat's cage is followed shortly by a painful electric shock. The animal soon learns the "meaning" of the light and, in its presence, manifests anxiety: shaking, tachycardia, crouching, urinating, and defecating. If he had previously been working on a task (e.g., pressing a bar to obtain food) in the presence of the light (i.e., the anxiety condition), he stops working and remains immobilized. However, administration of



Chlordiazepoxide Diazepam

Oxazepam Clorazepate

Lorazepam Prazepam

Halazepam Alprazolam

FIGURE 1. Benzodiazepines for the treatment of anxiety.

a benzodiazepine would allow the animal to keep on working despite the anxiety-producing stimulus.

Benzodiazepines block nervous system stimulation that originates in the brainstem reticular system and diminish activity in areas associated with emotion such as the septal region, amygdala, hippocampus, and hypothalamus. Benzodiazepines

TABLE 2. Benzodiazepine Antianxiety Drugs

Drug	Approximate dose equivalents (mg)	Available dosage forms	Rapidity of absorption	Active metabolites	Half-life (hr)
Alprazolam (Xanax®)	0.5	0.25-, 0.5-, and 1.0-mg tablets	Intermediate	α-Hydroxyalprazolam, desmethylalprazolam, 4-hydroxyalprazolam	6 to 20
Chlordiazepoxide (Librium® and others)	10	5-, 10-, 25-mg tablets and capsules, 100-mg/2-ml ampule	Intermediate	Desmethylchlordiazepoxide, demoxepam, desmethyldiazepam, oxazepam	5 to 30
Clorazepate (Tranxene®)	7.5	3.75-, 7.5-, and 15-mg capsules (Tranxene®)	Fast	Desmethyldiazepam,[a] oxazepam	30 to 200
Diazepam (Valium®)	5	2-, 5-, 10-mg tablets, 10-mg/2-ml ampules, 50-mg/10-ml vials, 10-mg/2-ml syringe	Fastest	Desmethyldiazepam, oxazepam	20 to 100
Halazepam (Paxipam®)	20	20-, 40-mg tablets	Intermediate	Desmethyldiazepam, oxazepam	Ca. 14 (parent), 50 to 100 desmethyldiazepam
Lorazepam (Ativan®)	1	0.5-, 1-, 2-mg tablets, 2- and 4-mg/ml syringes, 2- and 4-mg/ml vials[b]	Intermediate	None	10 to 20
Oxazepam (Serax®)	15	10-, 15-, 30-mg capsules, 15-mg tablets	Slower	None	5 to 15
Prazepam (Centrax®)	10	5-, 10-mg capsules, 10-mg tablets	Slowest	Desmethyldiazepam,[a] oxazepam	30 to 200

[a] These drugs are pro drugs for desmethyldiazepam: the parent compound is rapidly converted to the active metabolite.

[b] As of this writing, approved by FDA only for preanesthetic use.

raise the seizure threshold and increase the frequency and activity of brain waves—effects that resemble those of other sedative–hypnotic drugs such as barbiturates.

In one experiment, a single dose of diazepam administered to a group of healthy volunteers impaired both immediate and delayed free recall by interfering with the acquisition of new information. Retention remained unaffected. After 3 weeks of diazepam administration, partial tolerance developed to the memory impairment, and 1 week following discontinuation of diazepam, memory returned to normal.[12]

The benzodiazepines' mechanism of action has not been completely elucidated. They interact with specific brain receptors, and they probably resemble an endogenous ligand to these receptors. Benzodiazepine receptors are located in areas of the brain that might explain some of the pharmacological activity of benzodiazepine drugs.[13] Benzodiazepine receptors in the limbic system (hippocampus and olfactory bulb) may mediate antianxiety effects; receptors in the cortex might explain anticonvulsant activity; and receptors in the thalamic nuclei could be involved in sedative effects. The interaction between drug and benzodiazepine receptor allows increased activity of the inhibitory neurotransmitter γ-aminobutyric acid (GABA).

Prolonged administration of benzodiazepine compounds may "turn off" the synthesis of endogenous benzodiazepinelike substances. Various withdrawal effects following drug discontinuation could, in turn, be caused by changes in receptors that follow long-term administration. The time required for recovery from benzodiazepine withdrawal symptoms would then reflect the time it takes either to regenerate an endogenous ligand or to reset receptor sensitivity.

The effects of benzodiazepines on the other organ systems show a strikingly benign pattern. Although decreased respiration, blood pressure, and cardiac output may be observed, they are unlikely to be of clinical consequence. In fact, clinicians have safely administered these drugs to large numbers of patients with disease of the heart, blood vessels, and lungs.

Diazepam, especially, produces significant skeletal muscle relaxation, probably by direct action on spinal neurons. Physicians have administered this drug to many patients with skeletal muscle spasm, spasticity, and other muscle disorders, although its efficacy remains to be proved beyond doubt.

3. Kinetics

The rate at which a drug is absorbed from the gastrointestinal tract determines to a large degree the rapidity of onset and intensity of its acute effects.[14] Among benzodiazepine compounds, the rate of absorption varies considerably (see Table 2). Thus, diazepam and clorazepate reach the blood rapidly and produce prompt and intense effects following a single oral dose: peak concentrations of diazepam may be reached within an hour (even more rapidly in children), which could account for occasional reports of euphoria with diazepam. On the other end of the absorption spectrum, prazepam (and, to a lesser degree, oxazepam) is more slowly absorbed.

resulting in a less intense and more delayed onset of action and side effects after single doses.

For any drug, absorption is most rapid when medication is taken on an empty stomach. Anything that delays gastric emptying, such as food or aluminum-containing antacids, will slow drug absorption, resulting in delayed onset and diminished intensity of acute clinical effects.

After a single dose of a benzodiazepine drug, its action is terminated primarily by drug distribution, which correlates with its lipid solubility. Thus, diazepam, the most lipid-soluble benzodiazepine, is rapidly and extensively distributed to body tissues following a single oral dose. Even though diazepam has a long elimination half-life, following a single dose its duration of action is relatively brief. Moreover, some degree of central nervous system tolerance also appears to diminish the initial action of the drug, even before blood levels have shown much decline. Less extensively distributed drugs, such as lorazepam, have a longer duration of action after a single dose, even though lorazepam's elimination half-life is much briefer than diazepam's.

Plasma concentrations of benzodiazepine drugs (and their active metabolites) probably correlate to some degree with clinical response, although this relationship is complicated by tolerance that develops within the central nervous system. At present, measurements of benzodiazepine concentrations in blood are not of general clinical use, although studies have correlated unwanted effects of these drugs with blood levels, which may provide clues to problems of overdose and withdrawal.[15]

Benzodiazepines bind tightly to plasma protein and are highly lipophilic, which means they are difficult to remove from the body by dialysis. They probably recirculate enterohepatically, which could account for an occasional secondary rise in blood levels several hours after the initial rise.

Benzodiazepines are metabolized in the hepatic microsomal enzyme system. Many are biotransformed into desmethyldiazepam—a major active metabolite of diazepam and halazepam and a metabolite of chlordiazepoxide. In addition, clorazepate and prazepam have little pharmacological activity themselves but serve as precursors for desmethyldiazepam. The conversion of clorazepate to desmethyldiazepam occurs rapidly but depends on an acid medium in the stomach, which is compromised by the presence of antacids or food. The transformation of prazepam to desmethyldiazepam occurs more slowly, accounting for the gradual onset of effects with that drug. The metabolic pathways that transform drugs to desmethyldiazepam are influenced by factors such as age, liver disease, or the coadministration of other drugs that may affect hepatic oxidizing activity.

Three benzodiazepines—oxazepam, lorazepam, and the hypnotic temazepam—have no active metabolites and are simply conjugated with glucuronide in the liver. The elimination half-lives of these compounds are in the short to intermediate range. Their metabolism is less affected by the presence of liver disease, the extremes of age, or drug interactions.

Of what use to a clinician is a drug's half-life? First, the half-life determines the time required to achieve a "steady-state" concentration, which occurs in about four half-lives. (At steady state, the amount of drug excreted equals the amount ingested, i.e., a dynamic equilibrium.) Until a drug reaches steady state, it is accumulating, which means that the optimal dosage cannot yet be determined for a given patient. For example, an elderly woman in a nursing home may gradually become more sedated over the first several weeks on a chlordiazepoxide regimen. The drug is continuing to accumulate in her body until steady state is achieved, which may take longer in an elderly patient. For this reason, the clinician must be aware of this lag and adjust dosage accordingly.

A second significance of the half-life is with regard to the frequency of dosing. Drugs with half-lives greater than 24 hr often may be administered in once-daily doses, whereas drugs with short half-lives should be administered more frequently to achieve constant clinical effects. A third implication concerns the other end of the treatment program—termination. Drugs with long half-lives have more built-in tapering: when they are discontinued, their rates of egress from the body are relatively slow. Even so, all benzodiazepines should be discontinued by tapering rather than by abrupt discontinuation, but this is even more of a concern with short-half-life agents.

4. Adverse Effects

The most common unwanted effects of the benzodiazepines (as for other central nervous system depressants) are drowsiness and ataxia, which acutely correlate with elevated blood concentrations of the drugs (and active metabolites). At even higher levels, gross psychomotor impairment and marked sedation occur. The elderly may be more vulnerable to these reactions because they usually achieve higher blood (and tissue) drug levels for a given dose and also because the aging brain is more sensitive to the effects of sedatives.

An increased tendency to express hostility, particularly in group settings, has been reported with diazepam, chlordiazepoxide, and alprazolam but may be less of a problem with oxazepam. Data on this point remain inconclusive,[16] but clinicians may wish to avoid high-potency benzodiazepines in patients who have trouble containing their anger. Occasional patients become depressed during chronic benzodiazepine therapy, but whether this is a causal association remains in doubt.

Aside from the effects noted above, adverse reactions with benzodiazepines tend to be uncommon and are rarely serious. Occasional patients experience increased appetite and weight gain, cutaneous (usually allergic) reactions, nausea, headache, and assorted endocrine changes. Rare reports describe agranulocytosis and cholestatic jaundice, but unusual events in association with drug therapy do not prove an association with the drug. A few investigators have raised the possibility of a relationship between diazepam use and mammary tumors in laboratory animals and in humans; however, a careful review of the data does not support a causal association.[17]

5. Toxicity

Probably the nicest feature about the benzodiazepines is their very high therapeutic index—the ratio of toxic to therapeutic doses. Although frequently ingested in overdose attempts, benzodiazepines alone almost never cause fatalities.[18,19] The combination of a benzodiazepine with alcohol or other sedative–hypnotic agents is more hazardous, although it is unclear whether or not the benzodiazepines actually contribute to the lethality of the combination.[20]

Whenever possible, the use of any drug during pregnancy should be avoided. Some but not all data suggest that benzodiazepines taken during the first trimester may cause an increased incidence of cleft lip/cleft palate. Used late in pregnancy or during nursing, benzodiazepines have been associated with a "floppy infant syndrome." Other observations in infants whose mothers have taken benzodiazepines have included multiple congenital deformities, intrauterine growth retardation, withdrawal symptoms, neonatal depression with poor sucking and hypotonia, hyperbilirubinemia, hypothermia, increased carbon dioxide tension and acidosis, and cardiac arrhythmias (many of which may be coincidental)[21] (see Chapter 10).

6. Tolerance, Dependence, and Withdrawal Reactions

Benzodiazepine drugs have been sought out for "recreational" purposes, i.e., to induce a euphoric state, a "high." Some may have a greater abuse potential than others, conceivably related to their pharmacokinetics (e.g., rapid absorption and onset of action). In general, given the extent of therapeutic use, however, the specific abuse of these drugs has been relatively rare. On the other hand, clinicians typically should not prescribe the benzodiazepines to patients with a history of substance abuse, particularly with sedative–hypnotics. Any suggestion that a patient is taking more of the drug than prescribed should be viewed with concern.

Benzodiazepine withdrawal leads to reactions similar to those observed with other sedative–hypnotic compounds (e.g., barbiturates, alcohol). Cross-tolerance exists among these various classes, and one agent usually can treat a withdrawal syndrome from another. In fact, benzodiazepines are frequently employed in treatment of alcohol-withdrawal syndromes.

We used to believe that withdrawal reactions to benzodiazepines were relatively rare and occurred only when the drugs were used in dosages considerably in excess of therapeutic recommendations. More recently, however, clinicians have observed that patients taking benzodiazepines for long periods of time—even at standard doses—are vulnerable to withdrawal reactions when the drug is abruptly discontinued (possibly because of a "turning off" of endogenous benzodiazepine substances)[22] and to withdrawal symptoms after discontinuing short-term use of some agents, such as alprazolam.

Mild withdrawal symptoms include insomnia, dizziness, headache, anorexia, vertigo, tinnitus, blurred vision, and shakiness. Some of these symptoms may represent a recurrence of anxiety that had been contained by the benzodiazepine. However, if after discontinuing the drug these symptoms increase over several weeks and then begin to wane, a rebound or withdrawal reaction is more likely.

Severe signs of benzodiazepine withdrawal include hypotension, hyperthermia, neuromuscular irritability, psychosis, and seizures. Short-acting benzodiazepines, with their relatively rapid egress from the body, might cause a higher incidence of severe withdrawal reactions, including convulsions.

Benzodiazepine Withdrawal Syndrome

- Anxiety
- Agitation
- Tremulousness
- Insomnia
- Dizziness
- Headaches
- Tinnitus
- Blurred vision
- Diarrhea
- Hypotension
- Hyperthermia
- Neuromuscular irritability
- Psychosis
- Seizures

7. Drug Interactions

Benzodiazepines interact with relatively few other drugs, so they can be coadministered safely with various medical and psychiatric medications. Benzodiazepines have relatively little tendency to induce hepatic microsomal enzymes, especially in comparison with barbiturates and other sedative–hypnotics, which means they usually can be administered to patients taking anticoagulants.

A common pharmacodynamic interaction (i.e., additive effects on target organs) is the **enhancement of central nervous system depression when a benzodiazepine is coadministered with another sedative, including alcohol.** It is doubtful whether coadministration of alcohol with diazepam can increase blood concentrations of diazepam (a pharmacokinetic interaction).

A handful of pharmacokinetic interactions involving benzodiazepines have been reported (see Table 3). In general, benzodiazepines that undergo conjugation as the only metabolic step in biotransformation (i.e., oxazepam, lorazepam, temazepam) have the fewest kinetic interactions. Diazepam increases plasma levels of the anticonvulsant phenytoin (Dilantin® and others) and of the cardiac drug digoxin (Lanoxin® and others). When disulfiram is coadministered with chlordiazepoxide and diazepam, blood levels of the benzodiazepines can rise. Antacids should not be administered at the same time as clorazepate, since they will diminish the biotransformation of clorazepate to the active compound desmethyldiazepam, thus reducing its potency. Antacids and foods slow the absorption of other benzodiazepines but do not diminish the total amount absorbed. Cimetidine (Tagamet®), used for the treatment of acid peptic disease, increases the blood levels of long-

TABLE 3. Benzodiazepine Interactions[a]

Diazepam (Valium®)	↑ Phenytoin (Dilantin® and others) levels
Diazepam	↑ Digoxin (Lanoxin® and others) levels
Disulfiram (Antabuse®)	↑ Chlordiazepoxide (Librium® and others, diazepam levels
Antacids	↓ Clorazepate (Tranxene®) absorption; slower chlordiazepoxide, diazepam absorption
Food	Slower diazepam absorption
Cimetidine (Tagamet®)	↑ Levels of long-acting benzodiazepines
Alcohol	? ↑ Diazepam levels; potentiates CNS-depressant effects

[a] From Gelenberg.[23]

acting benzodiazepines (e.g., diazepam, chlordiazepoxide, clorazepate, prazepam) but does not appear to affect the short-acting agents (e.g., lorazepam, oxazepam, temazepam).[23]

8. Nonpsychiatric Uses

Benzodiazepines have a number of uses outside of psychiatry: as anticonvulsants, for premedication before surgery and other procedures (such as cardioversion and endoscopy), in treatment of alcoholic withdrawal states, and as muscle relaxants in such diverse conditions as muscle strain, tetanus, spasticity, and stiff-man syndrome.

B. Buspirone

In light of such evident benzodiazepine drawbacks as sedation, visual motor and memory effects, possible abuse, and discontinuation syndromes, there was considerable enthusiasm and eager anticipation for the new nonbenzodiazepine anxiolytic buspirone (BuSpar®). With a pharmacological profile quite different from other anxiolytic agents, this azaspirodecanedione is a lipophilic heterocyclic compound that lacks sedative, anticonvulsant, or muscle relaxant properties and thus has been deemed "anxioselective." Considerable research and clinical experience documents lack of abuse potential, and the drug has no significant interactions with either alcohol or other central nervous system depressants. The mechanism of action of buspirone does not appear to involve interaction with a benzodiazepine–GABA receptor. It does have a number of complex interactions with dopamine receptors, particularly presynaptic ones, as well as postsynaptic 5-HT_{1A} (serotonin) receptors, for which it is a partial agonist. Despite its effects on dopamine receptors, it does not appear to be a neuroleptic or to have a neuroleptic side-effect and risks profile.

A considerable body of clinical trials indicates that buspirone's effectiveness is comparable with that of benzodiazepines in the treatment of generalized anxiety.[24] There is some evidence that patients with prior treatment with benzodiazepines do rather less well with buspirone than treatment-naive patients.[25] Buspirone is available in 5-mg tablets, and the typical range of effective doses is between 5 mg t.i.d. and 15 mg t.i.d.

Despite reports to the contrary, many clinicians and patients have found buspirone to be a generally disappointing alternative to benzodiazepines. Ineffective in panic attacks, it has proven less than optimal in the treatment of many patients with generalized anxiety as well. Part of the explanation may be that the prescribing of buspirone requires a strategy similar to that of antidepressants, since there is a latency to respond of several days and, for individual patients, a critical dose threshold needed to achieve maximum benefit. Even with optimizing treatment by strategies of dose titration and sufficient duration of treatment, many patients still fail to show improvement. Nonetheless, some successes are achieved (some patients continued on benzodiazepines have improved or required lower doses of the benzodiazepine when buspirone was added). Given its several advantages, and despite uncertainties about general efficacy, a trial of buspirone is to be recommended for persistently anxious patients; for those who do respond to it, their course of treatment, and particularly their eventual discontinuation, may prove less complicated.

C. Other Antianxiety Agents

With the availability of the benzodiazepines, most previously employed antianxiety drugs have become obsolete. However, there are times when a physician may seek an alternative, for instance, in a patient liable to substance abuse. In addition, a doctor may "inherit" a patient who is already taking another type of drug, and thus we should all have some familiarity with other antianxiety compounds.

1. Antihistamines

Because of their sedative effects, drugs that block central and peripheral histamine receptors (primarily H_1) have, largely in the past, been occasionally used to calm anxious patients. Of the antihistamine drugs, clinicians prescribe hydroxyzine (Atarax®, Vistaril®, and others) most often. As shown in Fig. 2, it is chemically unrelated to the antipsychotics, antidepressants, benzodiazepines, or meprobamate.

Data about hydroxyzine metabolism in man are sparse. Apparently the drug is rapidly absorbed, begins to act within 15 to 30 min after a single oral dose, reaches peak plasma levels with in 1 hr, and maintains its effect for at least 24 hr. In addition to its sedative and antianxiety effects, hydroxyzine also possesses antiemetic and antihistaminic properties. It may be more sedating than the benzodiazepines, although in some patients it can cause agitation. Although not as effective an anxiolytic as the benzodiazepines, hydroxyzine does not cause physical dependence or abuse; therefore, it may be used as an alternative for patients prone to drug depen-

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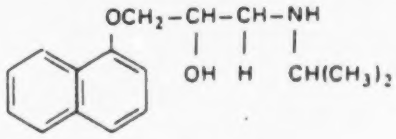
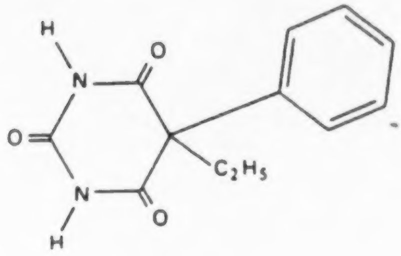


Propranolol



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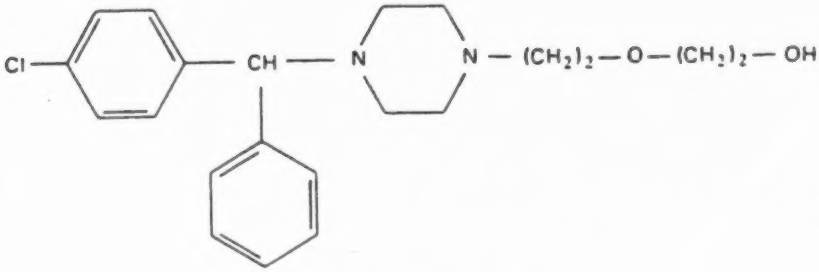
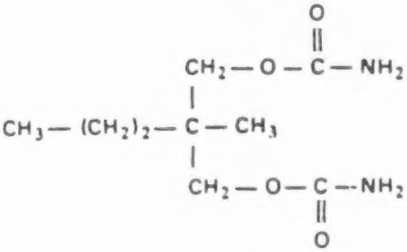


Hydroxyzine



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Meprobamate

FIGURE 2. Other drugs used for the treatment of anxiety.

dence. Usual daily doses range from 200 to 400 mg per day in two to four divided doses, which can be administered intramuscularly as well as orally.

In addition to the treatment of anxiety, hydroxyzine has been used for motion sickness, as a preanesthetic medication, and to treat allergic dermatoses. It is not effective for treating alcohol withdrawal syndromes.

Fatal overdose is uncommon with hydroxyzine, and withdrawal reactions have not been observed. Occasionally, cases of abnormal involuntary movements have been reported with antihistamines. Hydroxyzine may be teratogenic when administered to a pregnant woman, but this has not been studied definitively. Whereas benzodiazepines and most other sedative–hypnotic drugs elevate the seizure threshold, antihistamines depress the threshold and thus should be used with caution in patients with seizure disorders. Both peripheral and central anticholinergic toxicity can occur with antihistamine drugs; the elderly tend to be more sensitive to these actions. On a pharmacodynamic basis, hydroxyzine may show additive toxicity with other drugs that possess CNS-depressing antihistaminic or anticholinergic activity.

2. Barbiturates

The benzodiazepines, which have a much more favorable clinical profile, have largely replaced the formerly popular barbiturates for the treatment of anxiety. Barbiturates are classified according to their duration of action, speed of metabolic degradation, and hypnotic potency. Rapidly acting barbiturates are primarily inactivated through metabolism by the hepatic microsomal enzymes of the liver, whereas phenobarbital is eliminated largely unchanged by the kidney.

Barbiturates have a wide variety of effects on the body. They are CNS depressants and, in doses only several times greater than therapeutic, can depress the central respiratory drive. In toxic doses, barbiturates also depress cardiac contractility. Barbiturates interfere with the microsomal drug-metabolizing system in the liver and thus interact with various other drugs.

Barbiturates, most notably phenobarbital (Tedral® and others), probably have some degree of efficacy in the treatment of anxiety, but they seem to be less effective than the benzodiazepines and produce more sedation. It is likely that tolerance develops to antianxiety effects, which most probably result from their sedative activity. Clinical use of these agents is further complicated by the drugs' tendency to induce dependence, to cause serious withdrawal reactions, and to be dangerous in overdoses.

A barbiturate overdose can be extremely serious. Doses in excess of ten times a standard hypnotic dose are generally dangerous. Death occurs in approximately 0.5% to 12% of cases. Short-acting barbiturates are more toxic than the longer-acting agents: 2 to 3 g of amobarbital (Amytal® and others), secobarbital (Seconal®), or pentobarbital (Nembutal® and others) can cause death; in contrast, a lethal dose of the long-acting phenobarbital begins at about 6 to 10 g. Similarly, lethal blood concentrations may be 6 mg/100 ml for phenobarbital and barbital but only 1 mg/100 ml for shorter-acting agents. Obviously, the presence of alcohol or other central nervous system depressants can cause death at lower barbiturate concentrations.

Patients who are moderately intoxicated with barbiturates show central nervous system signs: nystagmus, slurred speech, sedation, and ataxia. More severe levels of intoxication can lead to coma, depressed reflexes, and diminished cardiac contractility. Treatment consists of support of vital functions. Elimination of the drug may be hastened by the use of dialysis or hemoperfusion.

Adverse effects of barbiturates primarily reflect CNS depression. The dose necessary to affect respiration is not much higher than the therapeutic dosage, which gives these drugs a relatively low therapeutic index. Withdrawal reactions are similar to those described for the benzodiazepines but are likely to be much more severe, associated with a high incidence of seizures, and potentially fatal.

Aside from potentiating the sedative and CNS-depressing effects of other similar drugs, barbiturates can interact pharmacokinetically with many other agents, especially oral anticoagulants. **It is best to avoid coadministering barbiturates with anticoagulants,** but if it is unavoidable, the clinician should closely monitor the anticoagulant dosage and prothrombin time.

Barbiturates are contraindicated in patients with acute intermittent porphyria.

3. Propanediols

Meprobamate (Miltown® and others) and tybamate (no longer available in the United States), two propanediols, are labeled for use as antianxiety agents. Meprobamate was an extremely popular drug in the 1950s, but controlled studies have failed to demonstrate its superiority over the barbiturates for treating anxiety. For a vast majority of anxious patients, there is little reason to prescribe one of these drugs. Moreover, adverse effects, interactions, liability to abuse, and withdrawal syndromes resemble those observed with the barbiturates.

The structure of meprobamate is depicted in Fig. 2. The propanediols, similarly to the barbiturates, are metabolized mainly by hepatic microsomal oxidases and also induce these enzymes. The half-life of meprobamate is about 12 hr, and that of tybamate about half as long.

Pharmacological and clinical effects, toxicity, hazards, tolerance, withdrawal reactions, and interactions of meprobamate and tybamate are all similar to those of the barbiturates.

4. β Blockers

Propranolol (Inderal® and others) block β-noradrenergic receptors in the peripheral sympathetic nervous system and probably centrally as well. Although some β blockers discriminate between β_1 (cardiac) and β_2 (pulmonary) receptors, propranolol blocks both receptors competitively and without discrimination. Propranolol's structure is depicted in Fig. 2. Propranolol is almost completely absorbed following oral administration, but only about one-third of the administered drug reaches the systemic circulation, largely because of extensive first-pass metabolism in the liver. As with most drugs, plasma concentrations after a given dose of the drug vary widely among different people. The acute half-life of propranolol is about 3 hr, but with chronic administration it increases to about 4 hr. The drug is largely bound to plasma protein, which may make total blood concentrations less reliable as earlier, asthma is a contraindication to the use of this drug. Patients taking insulin for the control of diabetes may be more susceptible to hypoglycemia when they take propranolol. Other unwanted effects include nausea, vomiting, diarrhea and constipation, depression, delirium, psychosis, and allergic reactions.

5. Antipsychotic Drugs

At times, clinicians use antipsychotic drugs for the control of anxiety. However, phenothiazines and related compounds are generally less effective for treating anxiety than the benzodiazepines, and the former produce a wider range of more serious adverse reactions, particularly long-term neurological effects (namely, tardive dyskinesia). For these reasons, minimize the use of antipsychotic drugs to treat nonpsychotic anxiety. Occasionally, considerations of abuse, failure to achieve satisfactory response with benzodiazepines, or the presence of overwhelming anxiety (as in the borderline personality) may suggest the use of low doses of an antipsychotic drug. In such cases, the physician should administer the lowest effective dose for the shortest period of time, carefully monitor the patient, periodically reevaluate the dose, and use necessary precautions (see Chapter 4).

D. Antidepressants

Although last in our list of available agents for treatment of chronic anxiety, antidepressant agents in general are an underutilized class of drugs for the treatment of persisting anxiety, even when not associated with depression (see Chapter 2). Failure to appreciate the possible efficacy of antidepressants, not just for panic attacks but also for generalized anxiety,[26] may result from the fact that these agents require adequate doses and duration of treatment, as in the treatment of depression. Although such anxiolytics as the benzodiazepines may demonstrate efficacy within the first few hours or days of dosing, antidepressants may require several days or weeks to be efficacious; thus, clinicians may have overlooked their usefulness when compared to the more rapidly acting alternatives. Nonetheless, where benzodiazepines and tricyclic antidepressants have been compared, by the end of 6 weeks, antidepressants are typically comparable in efficacy to the benzodiazepines (and may go on to offer greater improvement). For clinical settings where a clinician wishes to avoid the administration of a benzodiazepine, therapeutic trials of antidepressants may be worth considering.

VI. PHARMACOTHERAPY OF ANXIETY

A. Introduction

Of all the anxiolytic drugs we have just reviewed, the benzodiazepines are the most popular: they are both highly effective and have a broad margin of safety. The and cognitive strategies will possibly be sufficient. Optimal results frequently call for a multimodal approach.

Reviewing alcohol or other substance use history is critical, as is a general review of systems and prescribed medications. Physical examination, laboratory assessments (which may include electrolytes, calcium, magnesium, as well as liver and thyroid function tests), and an electrocardiogram (EKG) are useful baseline measures.

C. Discussing Treatment with the Patient

Once a decision is made to prescribe antianxiety medication, the physician should discuss the treatment plan and advise the patient about potential hazards such as possible problems driving, morning rebound or sedative carryover, and dangers of taking alcohol or other sedative–hypnotic drugs concomitantly. In addition, the clinician will want to suggest that prescription of an antianxiety agent is intended for a limited period of time and that the need for medication will be reevaluated regularly. Also, women who may become pregnant should be advised about potential hazards to the fetus.

D. Panic Attacks

Although treatment of panic attacks early in the course of the disorder may prevent complications, many patients seek treatment after years of symptoms and disability. Even in the face of chronicity, however, most patients achieve substantial if not dramatic benefit with antipanic pharmacotherapy as well as behavioral and cognitive therapies. Given the apparent primacy of the panic attack in the distress and evolution of complications of panic disorder, one approach is to initiate antipanic medications for patients continuing to experience panic attacks, with the expectation of regression and remission of complications once the attacks have ceased. For patients with residual phobic avoidance despite prevention of panic attacks, behavioral and cognitive strategies are employed. (For some patients, behavioral and cognitive strategies are employed initially, especially when symptoms are limited to phobic situations and where the frequency and intensity of unexpected panic are minimal. Pharmacotherapy is subsequently applied if emergence or exacerbation of panic or depression attends the behavioral program.)

Imipramine (Tofranil® and others) has well-established efficacy in panic disorder,[27] usually in the same dosage range as for treatment of depression (150–300 mg/day), but some patients do well at lower doses.

Other tricyclic antidepressants are probably also effective [for example, desipramine (Norpramin® and others) is frequently employed to decrease the anticholinergic burden], but the drawbacks include delayed onset of benefit and treatment emergent adverse effects. In addition to such usual side effects as dry mouth, possibility of early relapse upon discontinuation. The abuse potential of alprazolam may be similar to other benzodiazepines and varies widely among clinical populations. Most well-informed panic and agoraphobic patients who have endured severe distress over time treat their medication with respect and understand the wisdom in maintaining the lowest effective dose. Thus, unless there is evidence that a particular patient is more at risk for abuse, the use of this agent is usually safe for this disorder. As with any benzodiazepine, without controlled prescribing for targeted symptoms, inappropriate use may occur.

Because alprazolam is a relatively short-half-life and high-potency benzodiazepine, discontinuing treatment without a **very gradual taper** tailored to the individual patient's sensitivity to decreasing doses may be followed by rebound symptoms (worsened anxiety) or a withdrawal syndrome.

With these drawbacks in mind, some clinicians initiate treatment with alprazolam and a tricyclic antidepressant with the goal of tapering alprazolam early and continuing treatment with the antidepressant. Although the combination is certainly effective, there is no evidence that the discontinuation of alprazolam is facilitated by this strategy. For patients who require a high-potency benzodiazepine but suffer rebound symptoms, the longer-acting high-potency benzodiazepine clonazepam has proved effective.[28]

With milligram-for-milligram potency about twice that of alprazolam, clonazepam's usually effective dose range for panic patients is between 1 and 3 mg/day given in the morning and at bedtime. Sedation will be the limiting factor in dose titration and is managed by initiating treatment with a low bedtime dose and titrating upward if symptoms persist and as sedation resolves. Initial doses as low as 0.25 mg at bedtime may be used in drug-naive patients or those particularly sensitive to benzodiazepines. Greater doses may be given at bedtime than in the morning to minimize sedation, but many patients function without sedation on equal a.m. and h.s. doses.

The effect of a given daily dose on panic attacks and generalized anxiety will be apparent within a few days. Some patients (fewer than 10%) develop depressive symptoms on clonazepam. Resolution of depressive symptoms typically occurs by lowering the dose or by introducing an antidepressant; clonazepam often can then be tapered with expectation of continued response to the antidepressant; combined treatment can be pursued if anxiety symptoms incompletely resolve with the antidepressant.

Despite the "pharmacological dissection" of anxiety neurosis into antidepressant-responsive panic disorder and benzodiazepine-responsive generalized anxiety disorder, increasing evidence suggests that a number of other benzodiazepines such as diazepam, clorazepate, and lorazepam also improve panic disorder. Whether their efficacy is indeed comparable to alprazolam and clonazepam is insufficiently studied; with a clearly effective shorter-acting alprazolam and longer-acting clonazepam, the need for additional antipanic benzodiazepines is not pressing.

A number of other agents have benefited some patients with panic disorder either alone or adjunctively with standard agents including β blockers, verapamil qualone (no longer available in the United States) and others], the benzodiazepines are more selectively anxiolytic, with less sedation and less morbidity and mortality in overdose and acute withdrawal. Since using a benzodiazepine represents a clinical decision to offer symptomatic relief, it is critical to evaluate the patient's ability to function.

Ideally, benzodiazepine drugs should be administered for short-term use, typically around a period of stress, and always within the context of an ongoing therapeutic relationship. The physician should see the patient for a follow-up visit within a week or two to assess the patient's overall clinical status and response to the medication.

In the real world, however, many patients are on maintenance therapy and take benzodiazepines for months and even years. Is this ever justified, and, if so, what are the risks? To address the latter first, benzodiazepines carry a potential for dependence, abuse, and withdrawal reactions (although all are probably less severe than with other sedatives). Furthermore, the probability of withdrawal reactions (and perhaps the severity) increases with the chronicity of exposure. Also, in occasional patients, long-term use of benzodiazepines may produce chronic sedation and apathy (probably because of excessive levels). To avoid promoting abusive, overly long, and unsupervised use of these substances, physicians should not prescribe large quantities of benzodiazepine drugs or give multiple refills.

Despite our best intentions, however, some patients do take benzodiazepines chronically and function in a relatively stable manner. How does one identify these patients, and how should they be managed? The answer is: empirically. If a patient has been taking a benzodiazepine drug for weeks or a few months, the physician should attempt gradually to taper the agent. Even at low doses and with small decremental decreases, the patient may experience a reemergence of anxiety. The clinician's dilemma is to differentiate between rebound and relapse. If the patient is able to bear the distress, the clinician should recommend that the patient maintain the lower dose or the drug-free state for approximately 2–4 weeks. Some patients will become symptom-free before that time, suggesting that rebound or withdrawal effects accounted for the transient worsening. In other patients, symptoms emerging after tapering persist, suggesting continued need for the drug. If anxiety symptoms (not a withdrawal reaction) regularly reemerge when the dose is tapered, and the patient has not shown a tendency to abuse the drug (e.g., to get "high," to increase the dose beyond the physician's prescription), then the most prudent course may be to allow the patient to continue chronically with the medication. Of course, the clinician should attempt to taper the drug periodically, possibly every 6 to 12 months, to find the lowest effective dose that can control symptoms (see Table 4 for dosage recommendations).

Tolerance does develop to the sedative effects of benzodiazepines, but it is less clear whether tolerance develops to their sleep-maintaining and antianxiety effects. The benzodiazepines probably do retain at least a proportion of their efficacy over many months and possibly longer.

Physicians should advise all patients who are taking benzodiazepines to consult

4. If medication is indicated, discuss plans with the patient
    a. Outline potential hazards (e.g., problems driving, hangover, additive effects with other drugs)
    b. Propose a short-term trial of drug therapy
    c. Discuss the need for periodic reevaluation
    d. Outline the potential harm to the fetus for women of childbearing age

5. Prescribe short-acting agents in divided doses; long-acting agents may be administered once or twice a day

6. Give benzodiazepines in low doses initially (in small, nonrefillable prescriptions) and increase until
    a. Anxiety is adequately contained
    b. Significant adverse reactions (particularly drowsiness) occur
    c. Recommended dose limits are reached

7. Discontinue drugs slowly (i.e., over several weeks—longer after prolonged therapy or with very high doses)

8. Consider nonbenzodiazepine antianxiety medications for patients who may abuse drugs

9. Only provide ongoing benzodiazepine therapy for patients who
    a. Have significant anxiety without medication
    b. Do not respond to other treatment measures
    c. Do not show signs of abuse

10. Reevaluate drug use
    a. When symptoms do not respond adequately to treatment
    b. When the patient requests increasing doses or requires high doses or prolonged administration
    c. When the period of acute stress passes or after several weeks of acute administration
    d. Every few months in patients on chronic medication

2. Choosing a Specific Benzodiazepine

The choice of a specific benzodiazepine is usually not critical, since all are equally effective for generalized anxiety symptoms. However, the clinician should consider pharmacokinetic differences that may help tailor the drug to the patient and situation. For example, the rapidity with which a specific benzodiazepine is ab-

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Biological Factors in Obsessive–Compulsive Disorders

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Biological variables in obsessive–compulsive disorder are reviewed. In several areas of inquiry, aberrations in obsessive–compulsive patients have been noted. Biological areas of inquiry include genetic, neuroanatomical, neurophysiological, neuropsychological, and biochemical factors. The available data at this time point to a chronic overaroused state in the obsessive–compulsive. However, they are too preliminary at this juncture to formulate one specific hypothesis. In addition, a diathesis–stress model is called for to accommodate the available data. Finally, it is suggested that the hypothesis of chronic overarousal implicated in this condition can serve a valuable heuristic function.

In recent years, there has been a reemergence of interest in biological approaches to psychopathology. This is particularly true with respect to schizophrenia and affective disorders. More recently, there has been increased interest in biological parameters associated with anxiety disorders, including obsessive–compulsive disorders (OCD). The purpose of this article is to review the major findings from genetic, neuroanatomical, neurophysiological, neuropsychological, and biochemical studies of OCD. Although these findings in many instances are rather disparate, they suggest intriguing possibilities, and some suggestions for future research are put forth.

Obsessive–compulsive disorder is a relatively rare, extremely debilitating condition which is highly refractory to treatment; see the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association [APA], 1980). The syndrome is manifested in cognitive and motoric components and may be accompanied by mood disorders such as anxiety and depression. The DSM-III (APA, 1980) definition of obsessive–compulsive disorder is:

> Obsessions are recurrent, persistent ideas, thoughts, images or impulses that are ego-dystonic; that is, they are not experienced as voluntarily produced, but rather as thoughts that invade consciousness and are experienced as senseless or repugnant. Attempts are made to ignore or suppress them. Compulsions are repetitive and seemingly purposeful behaviors that are performed according to certain rules or in a stereotyped fashion. The behavior is not an end in itself, but is designed to produce or prevent some future event or situation. (p. 234)

Salzman and Thaler (1981) noted several consistent characteristics of the disorder: (a) thoughts or actions over which an individual believes there is a lack of voluntary control; (b) the presence of anxiety due to the ego-dystonic nature of the thoughts; and (c) knowledge that the thoughts and actions are senseless and unreasonable, which nevertheless does not alter the need to perform the compulsive acts.

Obsessions are intrusive and unwanted thoughts, and the content is usually senseless and/or repulsive. Fears include worry over germs or contamination, over contracting an illness such as cancer, or about being responsible for someone's death or injury. Compulsions are repetitive, excessive, and unnecessary overt acts, which are the result of strong subjective urges, although strictly speaking the behaviors are under the individual's voluntary control. Two common forms of compulsions are excessive checking (e.g., oven gas jets, windows and locks, personal articles) and cleaning or washing of one's person or domicile (Turner & Michelson, 1984). Some individuals experience cognitive rituals (Sturgis & Meyer, 1981), in which a discrete

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number of steps must be performed for the act to be successfully completed. If there is any deviation, the individual must begin the sequence again. An example of a cognitive ritual would be the recitation of a series of statements or numbers. Regardless of form, rituals usually serve an anxiety-reducing function. In addition, obsessive–compulsives sometimes attribute magical qualities to their rituals, thinking the rituals have the power to ward off undesirable events. The compulsions can become so overwhelming that other activities become restricted because of time spent engaged in the compulsive behavior. In addition, family members are often drawn into the rituals and must likewise perform certain circumscribed acts. The course of obsessive–compulsive disorder is considered chronic with periodic exacerbation and diminution of the symptoms (DSM-III; APA, 1980).

Epidemiology

As is the case for all of the anxiety disorders, extensive epidemiological data are not available for obsessive–compulsive disorder. Thus, we know little about its incidence and prevalence or cultural patterns. As noted, obsessive–compulsive disorder is rare; it is estimated to affect 3% of the neurotic population or 0.05% of the general population (Sturgis & Meyer, 1981). Onset usually occurs in early adulthood (DSM-III; APA, 1980), and social behavior may be markedly impaired. Obsessives are reported to have celibacy rates as high as 72% (Coryell, 1981), to marry later, and to have lower rates of fertility (Turner & Michelson, 1984). Similarly, other epidemiological investigations (deSilva, Rachman, & Seligman, 1977; Hare, Rice, & Slater, 1971) reported high celibacy rates, particularly among men; they suggested this is proportional to severity of the illness. This pattern may be related either to specific obsessions (fear of contamination or infection) or to social isolation accompanying the secretive nature of the disorder and the restrictive rituals. Also, this pattern may be specific to Western cultures. Akhtar (1978) investigated marriage, celibacy, and fertility patterns in a sample of Indian obsessive–compulsive patients. In comparison with Indians suffering from generalized anxiety disorder and with obsessionals from other countries, the Indian obsessionals demonstrated lower rates of bachelorhood and celibacy. The obsessionals reported higher fertility rates than either comparison group. Akhtar attributed this discrepancy to the cultural demands and social taboos in India and the obsessional's inability to resist the pressures of conformity.

Relation to Other Psychiatric Disorders

Obsessive–compulsive symptoms are often found in other psychiatric conditions. The disorders known to have obsessional features are Lesch-Nyhaus Syndrome, anorexia nervosa, mental retardation, organic brain syndrome, epilepsy, head trauma, Parkinson's Disease, depression, schizophrenia, and Tourette's Syndrome. This list indicates there are a number of disorders with obsessional features similar to those found in obsessive–compulsive disorders. Moreover, a number of biological hypotheses regarding etiology of these disorders have been postulated, suggesting OCD might also have biological underpinnings. Before discussing biological abnormalities in OCD, we present evidence for the similarities of the symptom features between these disorders and OCD. In a later section, we evaluate the evidence for a shared biological base between these disorders and OCD where there has been sufficient research.

Schizophrenics often experience delusional thoughts and hallucinations that may be considered obsessional. For the most part, these are easily distinguishable, because the schizophrenic does not believe these thoughts are senseless and therefore they are not experienced as ego-dystonic (DSM-III; APA, 1980). Individuals who experience closed head injuries are sometimes reported to develop ritualistic or stereotypic behavior that may resemble compulsions. In these cases, the ritualistic behavior of the organically impaired group is more likely the result of impaired cognitive processes that prevent integration of new learning or the ability to vary performance on a particular task. On a clinical basis, the stereotypic behaviors do not appear to serve an anxiety-reducing function, nor do they appear to be purposeful in any fashion as in the case of obsessive–compulsive behavior. Moreover, organically impaired individuals do not appear to experience such behavior as being problematic (Turner & Michelson, 1984).

The existence of obsessive–compulsive symptoms in Tourette's disorder is striking, and this has been suggested as supporting a link between the two conditions (Elkins, Rapoport, & Lipsky, 1980). Various reports in the literature have indicated that obsessive-compulsive symptoms occur in the range of 33% to 89% of patients diagnosed as suffering from Tourette's syndrome (Cohen, Detlor, Young, & Shaywitz, 1980; Nee, Caine, Polinsky, Eldridge, & Ebert, 1980; Yaryura-Tobias, 1977). Additionally, obsessive–compulsive symptoms often appear in first-degree relatives of patients with Tourette's disorder (Montgomery, Clayton, & Friedhoff, 1982). In both disorders there are motoric manifestations. The behaviors are quite different, however. In Tourette's disorder, the uncontrollable behaviors consist of circumscribed body movements such as tics, extremity jerks, or involuntary vocalizations such as barks or grunts. This differs from OCD patients in two ways: First, the behaviors of the OCD patient are not limited to specific body movements and tend to be related to specific obsessive ideation. Further, rituals in OCD patients may be strictly cognitive. Second, rituals seen in OCD serve a purpose (e.g., compulsive handwashing prevents the possibility of infection). Nevertheless, the high percentage of Tourette's individuals who suffer concomitant OCD symptomatology is important in view of the proposed neurochemical aberration in Tourette's disorder. Pharmacological interventions such as L-dopa can precipitate Tourette's (Feinberg & Carroll, 1979), and some neuroleptics (such as Haloperidol) improve the condition, presumably by blocking dopamine receptors (Shapiro, Shapiro, Bruun, & Sweet, 1978). Because L-dopa and Haloperidol affect dopamine levels in the brain, and Tourette's syndrome patients and OCD patients have a number of similarities, the question arises as to the relation of the neurotransmitter dopamine in these disorders. We discuss the possible role of dopamine in OCD in a later section.

There is considerable evidence of an association between OCD and depression (Turner & Michelson, 1984). A significant proportion of individuals experience both disorders simultaneously. Gittelson (1966) reviewed the case histories of 398 patients with a diagnosis of psychotic depression. Thirty-one percent of the cases exhibited obsessional thoughts during the depressive episode. Kendal and Discipio (1970) reported high scores on the Leyton Obsessional Inventory for patients during a depressive episode. Interestingly, these scores were not substantially reduced after recovery from the depressive disorder. In addition, these authors reported that patients with obsessional personality features prior to a depressive episode were more likely to manifest obsessional thoughts during their illness. As further support that there is some overlap in these conditions, the incidence of depressive symptoms in OCD has been reported to range from 17% to 35% (Vaughn, 1976) to 34% (Sturgis & Meyer, 1981) to 66% (Solyom, Zamanyadeh, Ledwich, & Kenny, 1971). In a more recent study, Turner (1984) reported that 79% of a sample of 43 OCD patients requesting outpatient treatment in the Anxiety Disorders Clinic at Western Psychiatric Institute and Clinic over a 2-year period scored 17 or above on the Beck Depression Inventory, indicating a significant degree of depression. In a sample of 22 obsessive–compulsives, 91% scored a *t* score of 70 or above on the MMPI Depression scale. Thus, it is clear that depressive symptoms are part of the clinical picture in many OCD cases.

Because some level of depression often accompanies OCD, determining a primary diagnosis is sometimes difficult. One method used is to establish an etiological time line for the two disorders. In most OCD cases, patients report the appearance of depressive symptomatology after the onset of OCD (Sturgis & Meyer, 1981). Rachman and Hodgson (1980) reported that although 55% of their patients did not feel depressed at the onset of their obsessive–compulsive behaviors, there were many cases of secondary depression over the course of the illness. Similarly, Welner, Reich, Robins, Fishman, and Van Doren (1976) found that the pattern of OCD followed by depression was three times as likely to occur as that of an initial depression followed by OCD. Insel, Kalin, Guttmacher, Cohen, and Murphy (1982) reported the case of a woman diagnosed as OCD who, 3 months after onset of the disorder, developed depressive symptoms. Twelve years before, this woman had suffered a major depressive disorder unaccompanied by obsessive–compulsive symptoms. The woman was able to differentiate the two depressive episodes by describing the depressive feelings accompanying her OCD as being entirely different from the subjective quality of "being totally blue" that she experienced as part of her major depressive episode. Although speculation on the link between OCD and depression has existed for some time, it is clear that both conditions can and do occur independently. This example seems to indicate that a patient can discriminate depression associated with OCD from a separate depressive illness. However, the covariation of the symptom picture, and the hypothesized involvement of similar neurotransmitters in both conditions, make this a fertile area for further inquiry.

Genetic and Family Studies

As early as 1868, Griesinger reported obsessional symptoms in relatives of obsessive-compulsive patients (Inouye, 1972). The difficulty in determining a genetic or biological predisposition for OCD is similar to that for other psychiatric disorders. It is necessary to control or determine the influence of environmental factors.

Investigators examining genetic predisposition in OCD have used two major approaches: Family studies and twin studies. A major difficulty in all of these studies is the lack of consistent diagnosis of the disorder. Inouye (1965) described four pairs of twins in which the index cases were diagnosed as obsessive–compulsive disorder. The behaviors exhibited by one male proband included tics, uncontrollable yelling and blinking, and feeling compelled to stick needles into his body. These behaviors were first observed to have occurred at the age of 7. The behaviors of a second proband began at the age of 9 and included tics, coprolalia, grimacing, yelling, and moving of extremities. Using DSM-III criteria, both of these cases would appear to be consistent with a diagnosis of Tourette's Syndrome rather than OCD. Similarly, Tarsh (1978) described a pair of dizygotic twins in which one twin exhibited symptoms specifically about her body weight. She felt she was grossly overweight, which was factually incorrect. She worried constantly about her weight and refused to be weighed. In addition, she reportedly spent a great deal of time standing in front of a mirror counting her ribs. Although no information about actual weight loss was provided, the symptom pattern is suggestive of an eating disorder, perhaps anorexia nervosa, rather than obsessive–compulsive disorder.

Thus, in reviewing the genetic and family studies, clear determination of the diagnosis of OCD is somewhat difficult. Similar difficulties arise in determining whether relatives have obsessive–compulsive disorder or compulsive personality traits. Certain individuals may exhibit behaviors resembling symptoms of obsessive–compulsive disorder. However, they do not manifest true obsessions and compulsions. Rather they are perfectionistic and preoccupied with trivial details, rules, and order; they lack the ability to express warm and tender emotions; they insist that others submit to their way of doing things; they are excessively devoted to work and productivity; and they are indecisive (DSM-III; APA, 1980). The similarities between obsessive–compulsive disorder and the compulsive personality style are such that it may, at times, be difficult to clearly differentiate the two conditions. Therefore, concordance rates may vary dependent upon the definition used (Carey & Gottesman, 1981). Finally, most information has been gathered from case records rather than actual interviews with the probands and relatives. With these precautions in mind, evidence for a genetic basis in OCD is presented.

In one recent study of family patterns of OCD symptomatology, 27 patients with obsessive–compulsive disorder and their biological parents were interviewed (Insel, Hoover, & Murphy, 1983). The patients did not report any OCD symptoms in their parents. One proband, however, did report a son who had

Table 1
Incidence of Concordance for MZ and DZ Twins for Proband Diagnosed as Obsessive–Compulsive Disorder

Study	Monozygotic		Dizygotic	
	Concordant	Discordant	Concordant	Discordant
Inouye (1965)	8	2	2	2
Inouye (1972)	27	8	0	7
Tarsh (1978)	0	0	1	0
McGuffin & Mawson (1980)	2	0	0	0
Carey & Gottesman (1981)	5	10	1	14

Note. Inouye (1972) is a compilation of 15 studies of incidence of obsessive–compulsive disorder in twins.

compulsive checking behavior. Additionally, there was evidence of affective and depressive spectrum disorder in a subset of the parents. A second method of assessing OCD was the administration of the Leyton Obsessional Inventory to a subset of 10 patients' parents. Three of the 20 parents (2 parents for each patient) who completed the inventory scored more than two standard deviations above the mean. These parents appeared to have obsessional features without the corresponding resistance and interference noted in OCD patients. In effect, while exhibiting similar behaviors, the parents did not view their own behavior as maladaptive or interfering in their daily lives. The authors suggested that obsessional behavior could represent an inheritable "obsessional factor" which under certain environmental conditions might be manifested in symptomatic behavior.

Carey and Gottesman (1981) examined family patterns in relatives of OCD patients. They reported 6.2% of parents, 3.2% of siblings, and 6.2% of the children of index cases suffered an identifiable obsessive–compulsive illness, whereas 8.3% of parents, 6.4% of siblings, and 9.3% of children had obsessional features to their personalities. Although these incidence rates are higher than those found in the general population, such family studies do not rule out the effects of modeling or other psychological factors in the development of the disorder. The stronger weight given to twin studies over family incidence reports rests on the assumption that the environment affects twins equally; therefore, different concordance rates for MZ and DZ twins should reflect genetic inheritance. In evaluating concordance, rates must be compared with that produced by chance alone. Marks, Crowe, Drewe, Young, and Dewhurst (1969) calculated the chance concordance rate for OCD in MZ twins as follows: Accepting the .05% frequency of OCD in the general population and the estimate that 1 in 200 adults is an identical twin, then 1 in 400,000 could be expected to be a MZ twin with OCD. Thus, 1 in 800 million would be the expected probability of a pair of MZ twins with the same disorder. In fact, the concordance rate for OCD far exceeds this chance probability. The incidence of concordance and discordance for MZ and DZ twins in which the proband is diagnosed as OCD is presented in Table 1.

In a review of 15 early studies of incidence of OCD in twins, Inouye (1972) reported 27 MZ pairs concordant and 8 pairs discordant for OCD, whereas for DZ twins the rates were zero concordant and 7 discordant pairs. However, due to discrepancies in diagnoses and brevity of some of the case records, caution is advised in interpreting these data.

Carey and Gottesman (1981) reported a high concordance rate for OCD in monozygotic twins. The investigators reviewed 30 years of hospital case records (1948–1979) at the Maudsley and Bethlehem hospitals in England, selecting individuals who upon admission were diagnosed as obsessional neurosis or phobic neurosis. Fifty one twin probands (30 obsessional and 21 phobic), their twins, and their first-degree relatives agreed to personal interviews. All probands in the sample met DSM-III criteria for obsessive-compulsive disorder or phobic disorder. The interview included developmental and marital history, psychiatric status as measured by the

Present State Examination, the Leyton Obsessional Inventory, and a list of 20 common phobias. Two types of concordance rates were reported: Concordance for a twin receiving treatment for OCD and concordance for obsessional symptomatology with or without concomitant treatment. Concordance rates for those twins receiving treatment were 33% for MZ twins and 7% for DZ twins. For obsessional behaviors with or without treatment, the rates were 87% and 47%, respectively. This study also used a comparison group of unspecified phobic probands and established concordance rates in the twins for this disorder. Rates for the phobic twin receiving treatment was 13% for MZ and 8% for DZ twins.

There are no adoptive studies for OCD similar to those used in examining biological components of schizophrenia and affective disorders (Carey & Gottesman, 1981). However, McGuffin and Mawson (1980) described two pairs of MZ twins concordant for OCD but who had been separated for several years prior to onset of the disorder. In addition, each twin did not have knowledge of the other's illness prior to development of their own symptoms. Despite this separation, there was a remarkable similarity in symptoms within each pair. In view of their separation before symptom onset, this report is significant in that obsessive-compulsive behavior in each twin cannot be attributed to modeling or other psychological processes.

It appears that the higher concordance rate in MZ twins would implicate more than environmental factors in the development of OCD (Carey & Gottesman, 1981). However, it is also clear that there is little evidence for a Mendelian or sex-linked transmission. Therefore, one might postulate decreased gene penetrance (McGuffin & Mawson, 1980) or a vulnerability model in which, given a sufficient level, environmental stressors would combine with a genetic predisposition to precipitate the disorder. There is need for further research, however, before any definitive conclusions regarding genetic hypotheses or a vulnerability model can be reached.

In addition to genetic predisposition, Snowdon (1979) observed that mean family size of obsessionals is smaller than for a matched group of controls. This is apparently due to the tendency for some obsessive-compulsives to engage in low-frequency sexual contact, probably due to contamination fears. If obsessional symptoms do in fact run in families, this could explain lower fertility rates noted in families of individuals with OCD.

In determining evidence for a genetic basis in a disorder, gene linkage and genetic marker studies are often useful in postulating the location of the gene on a particular chromosome. *Linkage* is a term used to suggest that the gene alleles of two specific conditions may be found on the same chromosome. Suggestion of gene linkage is based on a high degree of covariance in phenotypic expression of two conditions. If the two conditions do covary, and the location of one of the alleles is known, one type of gene linkage would suggest that the loci of the second phenotypic condition is on the same chromosome. Thus, the particular site of an abnormality is identified. For example, the gene for a certain type of bipolar depressive condition has been posited to be located on the X chromosome between the locations for Xg blood group and certain forms of color blindness (Depue & Monroe, 1978). These conditions appear in tandem with bipolar affective states. An investigation of blood types and anancastic (obsessive) symptoms (Rinieris, Stefanis, Rabavilas, & Vaidakis, 1978) produced evidence of a significant association between blood group phenotype A and obsessional behavior. Patients with OCD had a significantly higher incidence of type A ($p < .001$) and a significantly lower incidence of type O ($p < .01$) than the general population. Depressives free of anancastic symptoms also demonstrated differences from normals, having a lower incidence of blood type A ($p < .05$) and a higher incidence of blood type O ($p < .05$). In comparison, schizophrenics and depressives with anancastic symptomatology did not differ from normal controls in incidence of blood type. One might hypothesize a continuum based on anancastic symptoms with phenotype A and identifiable OCD at one extreme, obsessional symptoms in depression and schizophrenia and perhaps decreased gene penetrance at the center, and depressive disorders without anancastic characteristics and a higher incidence of blood type O at the other end. Although reminiscent of the bipolar linkage studies, the research in OCD is at a comparatively crude stage, and any conclusions drawn must be regarded as tenuous.

In summary, the studies reviewed thus far present some basis for hypothesizing a biological predisposition for the development of OCD. This predisposition may take the form of a genetic aberration or some type of structural weakness. The lack of adoption studies, however, makes it difficult to evaluate the impact of the environment in the development of the disorder. In addition, the rare occurrence of the disorder has no doubt prevented the large-scale investigations necessary to provide confirmation of these suppositions.

Neurophysiological and Neuropsychological Studies

Evoked Potential Studies

In an effort to establish neurophysiological correlates of OCD, Ciesielski, Beech, and Gordon (1981) recorded average evoked potentials on three types of visual stimulation tasks for a group of obsessional patients and a matched group of nonpsychiatric controls. They postulated that an abnormality of the central nervous system (CNS), leading to more rapid and fixed learning than considered normal, may explain the rigidity of behavior often seen in OCD. The OCD patients did not experiment with various response strategies as did nonpsychiatric controls. The authors suggested that instability in the arousal system could affect learning in this way, but they did not propose a specific anatomical site responsible for this instability. It is important to note, however, that this rigid style is characteristic of OCD patients and may be a result of the disorder, and not necessarily an antecedent. Variation in information processing was demonstrated in the obsessive group but only when the stimulus was complex (e.g., a patterned stimulation as opposed to a flash projection). The OCD group exhibited smaller amplitude of evoked potentials (EPs) and shorter latencies in pattern discrimination. This coincides with the findings of other investigators who have suggested that the nature of the OCD abnormality stems from an abililty to become aroused in response to low levels of stimulation (e.g., Beech, 1971). As a possible explanation for this increased arousal potential, Ciesielski et al. (1981) suggested that the faster latencies observed in the OCD group could reflect an abnormality of neurotransmitter inhibitory processes.

A follow-up investigation (Beech, Ciesielski, & Gordon, 1983) with 16 subjects—8 OCD patients and 8 controls—essentially confirmed the earlier Ciesielski et al. (1981) report. Obsessionals had shorter latencies and smaller amplitudes than normals, and this difference became more apparent as task difficulty increased. This study presents findings contradictory to Beech's (1971) suggestion of enhanced arousal in OCD because increased arousal should result in higher peak amplitudes. In addition, a theory of reduced inhibition as a basis of OCD based solely on evoked potentials is somewhat speculative as differences in information processing have been demonstrated in other psychiatric disorders (cf. Spring & Zubin, 1978). It is unclear at this juncture if the EP differences noted in this study can be attributed to some type of generalized deficit associated with the psychopathological state in general.

EEG Studies

The results of several studies have suggested cerebral dysfunction in anxiety-disorder patients based on electroencephalogram (EEG) recordings. In an early study, using a mixed group of anxiety patients, Crighel and Solomonovici (1968) reported EEG abnormalities in two groups of psychiatric patients, the first suffering from neurasthenia and the second group of neurotic patients also evidencing symptoms of anxiety and/or depression. Patients in the second group evidenced a significantly higher number of recordings characterized as containing EEG alterations. The abnormalities were of two types: (a) alterations of the temporal leads either unilaterally on the left side or bilaterally or (b) temporal spikes in addition to a fast and ample rhythm. The authors observed that these abnormalities usually indicate overexcitability of the temporo-amygdala complex. Because this complex is integral in the regulation of emotional behavior, abnormalities are likely to be reflected in altered mood states. Thus, one might expect the anxiety disorders (including OCD) to show the same pattern of abnormality. Further studies using EEG technology could help to clarify the role of the temporo-amygdala complex in OCD as well as all of the anxiety disorders.

In contrast to the previously mentioned study, which sampled patients with unspecified anxiety symptoms, others have restricted their investigations to EEG patterns in OCD patients. Epstein and Bailine (1971) described the sleep EEG patterns of three obsessionals, noting that abnormalities in the form of theta waves and spiking were localized to the temporal region and were similar to patterns of temporal lobe epileptics, again implicating possible amygdala or limbic dysfunction. Further, the authors suggested that these similarities may be reflected in the abnormal behavior patterns evidenced in each group (i.e., the stereotyped repetitive behavior seen in psychomotor epilepsy and the rituals of the obsessive–compulsive patient). Additionally, the authors hypothesized that dream imagery may be similar to obsessional symptomatology, as dreams are not felt to be under conscious control. However, in this assessment, dream imagery was unrelated to obsessional ideation. Therefore, it appears that a waking state is necessary for appearance of OCD symptoms. The authors suggested that while a waking state is necessary, it may not be identical to a normal waking state. An alteration in arousal mechanisms, creating an altered waking state, might allow the release of normally inhibited ideas or behaviors manifesting in forced, uncontrollable thoughts. This study is limited by the small sample size, and thus conclusions drawn from these data must be regarded as tenuous, but they do suggest that EEG technology might be useful in exploring brain functioning in OCD patients.

Flor-Henry, Yeudall, Koles, and Howarth (1979) studied 11 OCD and 11 control patients, recording EEG levels during resting periods and two cognitive tasks. The subjects also participated in neuropsychological testing. Unlike the results of other studies (Crighel & Solomonovici, 1968; Epstein & Bailine, 1971), there were no statistically significant differences in EEG recordings between groups other than reduced left-temporal variability in OCD patients during the resting situation. Neuropsychological testing was consistent with a dominant frontal lobe dysfunction in 10 of the 11 patients. However, this study is subject to major methodological difficulties. Control subjects were not recruited for this particular study. Rather, hospital case records were reviewed and patients were matched on the variables of age, education, and full-scale IQ. No further description of the control group was provided. Thus, it is unknown if the control group comprised normal individuals or a group of psychiatric patients. If it was the latter, the control group's neuropsychological performance might not be representative of that of a nonpsychiatric sample. Also, although there were significant differences between groups on some of the neuropsychological variables, results were not consistent within the obsessive group and therefore cannot be considered characteristic of the entire sample.

In summary, the previously mentioned studies present some evidence for abnormal EEG patterns in obsessive–compulsive patients. The abnormalities are inconsistent and do not present a clear indication of the location of the disturbance. Several authors hypothesized that overarousal (Crighel & Solomonovici, 1968) or altered waking states (Epstein & Bailine, 1971) may be a contributory factor in the disorder. Such disturbances might implicate a dysfunction in one of the known arousal systems, although mere overactivity cannot explain the primary OCD behavior. However, a chronic state of overarousal might well leave one more vulnerable to the development of OCD. Therefore, the overarousal hypothesis is worthy of further study, and EEG technology is one way this might be done.

Neuroanatomical Studies

Although twin studies and diffuse EEG abnormalities provide some evidence for a genetic or biological predisposition for OCD, such hypotheses are limited as they do not specify an anatomical site that might be implicated in the disorder. In comparison with OCD, the etiology of several of the disorders previously listed (epilepsy, head trauma, organic brain syndrome, and Parkinson's Disease) which also have some characteristics similar to OCD, can be associated with the malfunction of specific neuroanatomical regions. The association of brain region to disorder is clearest in the case of Parkinson's Disease, where the basal ganglia have been identified as the malfunctioning anatomical site. Certain forms of epilepsy, in particular temporal lobe epilepsy, or psychomotor epilepsy, are associated with seizure foci in the temporal lobe. In each of these disorders, the symptoms include motoric stereotypy and repetition that resembles the repetitive, ritualistic acts of the obsessive-compulsive. There is some indirect evidence from the animal literature relating OCD-like behaviors to specific areas of the brain. Pitman (1982) provided the following case description of a hippocampectomized rat.

> He is remarkable for his intense and rigid behavior, which others find difficult to modify. . . . At work on a task, he often overdoes it and persists beyond the point at which others would give up. His behavior is sometimes quite peculiar in that he engages in odd rituals, which bear no relation to the task at hand. These [behaviors] often appear superstitious. (p. 139)

Pitman (1982) noted the behavior of these rats with damaged limbic structures was similar to the behavioral style characteristic of OCD patients.

Similar behavior in rats with hippocampal lesions has been reported by Devenport, Devenport, and Holloway (1981) and Morris, Garrud, Rawlins, and O'Keefe (1982). Thus, these data suggest a starting place in the search for a specific CNS site which may be involved in the disorder. In addition, hypotheses of neurophysiological dysfunction have been suggested as a means of explaining some of the more puzzling aspects of OCD, including the observation that performance of the rituals sometimes serves to increase rather than decrease anxiety (Turner & Michelson, 1984) or why alterations in mood rather than environmental events seem to precipitate the behavior (Ciesielski et al., 1981).

Leucotomies

The rationale for the use of psychosurgery to alleviate OCD evolved from animal studies in which bilateral frontal lobe ablations in chimpanzees resulted in decreases in levels of experimentally induced anxiety and frustration (Kelly, 1973). Spurred by these reports, Moniz (1936, cited in Kelly, 1973) suggested that similar psychosurgical procedures could be effective in patients exhibiting anxiety and obsessions. In further support of the importance of the cingulate regions, it has been reported that anterior capsulotomy (involving the cingulate region) was useful in relieving symptoms of OCD (Fodstad, Strandman, Karlsson, & West, 1982). The limbic system, long acknowledged as an anatomical site for emotional behavior (Papez, 1937), has been the target of surgical intervention in the treatment of OCD. The object of leucotomy operations has been to disconnect the orbital and medial frontal cortex from the limbic circuit (Kelly, 1973). Although early leucotomies were performed without much regard for precise anatomical location, later efforts were targeted at the lower medial quadrant of the frontal lobes, orbital convexity, and cingulate gyri. Kelly (1973) reported 17 cases of obsessional neurosis treated by limbic leucotomy. Seventy-five percent were reported as much improved or improved 6 weeks after their operations. Self-report measures used to assess psychological changes included the Maudsley Personality Inventory, the Beck Depression Inventory, the Hamilton Depression Scale, the Taylor Manifest Anxiety Scale, and the Middlesex Hospital Questionnaire. Following the surgery, decreases were reported in neuroticism, depression, anxiety, and obsessions. There were concomitant decreases in physiological arousal evidenced by a reduction in forearm blood flow, heart rate, and blood pressure. There was no decrease in intellectual functioning as measured by the Wechsler Adult Intelligence Scale. Symptomatology of the other 25% was unchanged postoperatively. At 1-year follow-up, all treatment gains had been maintained. It is important to note that no specific measures of obsessions and compulsions were used in this study. Thus, this places some limitations on the findings. For a discussion of measurement issues in OCD, see Turner (1982) and Mavissakalian and Barlow (1981).

Kelly, Walter, and Sargant (1966) examined the physiological effects of leucotomy on psy-

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chiatric patients with various diagnoses. Forty consecutive patients selected for psychosurgery were assessed pre- and postoperatively. Diagnostic categories included recurrent or agitated depression, chronic anxiety, phobic anxiety state, obsessional neurosis, and schizophrenia. However, the specific patient selection criteria and the procedures used to arrive at their diagnosis were not described. Bilateral frontal leucotomies or orbital undercutting techniques were used. Again, 75% of the patient group showed improvement and 25% remained unchanged. Preoperative baseline measures of physiological arousal were within normal limits for blood pressure and blood flow. Heart rate was slightly accelerated at 95 beats per min. At 6 weeks after treatment, all patients demonstrated significant decreases in all resting physiological measures. Those patients suffering from agitated depression and chronic anxiety improved the most, as measured by reductions in level of forearm blood flow, heart rate and blood pressure during resting periods, and stressful mental arithmetic tasks. In addition, self-reported levels of anxiety and scores on the Taylor Manifest Anxiety Scale significantly decreased. Patients suffering from schizophrenia, obsessional neurosis, and phobias did not evidence the same level of improvement 6 weeks postoperatively as those suffering from agitated depression and chronic anxiety. At 18-month follow-up (Kelly, Walter, Michell-Heggs, & Sargant, 1972), 50% of the obsessional patients showed a decrease in symptoms resulting from the leucotomy. The authors attributed this delayed improvement to the gradual relearning process the obsessional must undergo. They postulated that anxiety concomitant with OCD is limited to particular events (in comparison with generalized anxiety), and that the individual must have the opportunity to be repeatedly engaged in the idiosyncratic, previously anxiety-provoking situation before the beneficial effects of the leucotomy become evident. Again, no specific measures of obsessive ideation or compulsive behavior were used. Also, delayed improvement could be attributed to exposure to anxiety-provoking situations that occurred after treatment.

In a retrospective comparison of the effects of psychosurgery and other treatment interventions, Tan, Marks, and Marset (1971) compared the effect of bimedial leucotomy with other treatments for OCD in patients matched for sex, age, symptom duration, onset age, and OCD symptom severity. Although the exact nature of the other treatments was not delineated, the authors listed several interventions including drugs, electroconvulsive therapy (ECT), insulin, hypnosis, abreaction, and behavioral and dynamic psychotherapy. All subjects were diagnosed as suffering from obsessive-compulsive disorder. This study is also remarkable for its 5-year follow-up period. Categories of improvement included obsessions and compulsions, general anxiety, depression, and work adjustment. Independent ratings of improvement were made from hospital records using a 5-point rating scale used by two independent judges. After treatment, obsessions were significantly reduced in the leucotomy group but not in the control group. This difference held constant even at the 5-year follow-up period. For generalized anxiety, findings were again in favor of the leucotomy group during the first 3 months. However, at 5-year follow-up, the control subjects also were improved, thus negating the differences between the groups. Both groups also improved on the variable of depression. Work and social adjustment improved significantly more in the leucotomy group throughout the course of follow-up.

Decreases in OCD symptoms following dissociation of frontal-limbic neurons may make psychosurgery appear beneficial. However, the side effects of leucotomy can range from minimal to quite severe. Immediate side effects included urinary incontinence, headache, and transient confusion. Long-range side effects included poor memory and concentration, apathy, one case each of psychosis and epilepsy, sexual disorders, weight gain, and social disinhibition. The authors did point out that treatment gains were not "bought at the expense of a vegetable existence" (Tan et al., 1971, p. 160). Those who were unable to work adequately when assessed at the 5-year follow-up were those who retained their symptoms.

Leucotomy is an extremely controversial procedure and not widely accepted as an appropriate treatment intervention for OCD. The use of leucotomies in treatment of OCD, however, highlights the intractable nature of the disorder and the frustration that often accompanies the treatment of these individuals. In at least one study, the author emphasized that leucotomy was not the treatment of first choice, that selection of candidates was made with extreme caution, and that leucotomies were considered only in severely refractory, long-term cases where psychosurgery was preferable to continued life with the severely debilitating condition. To our knowledge, in the United States psychosurgery is not used in the treatment of obsessive–compulsive disorders. Advances in pharmacologic (antidepressants) and behavioral therapies (e.g., flooding and response prevention) have added new techniques to the treatment armamentarium for OCD such that treatment prognosis is now quite good (Turner & Michelson, 1984). Thus, it does not appear that the use of psychosurgical procedures is necessary.

In summary, the findings of neuroanatomical studies suggest that cerebral dysfunction might well be a factor in obsessive–compulsive disorders. The results of the leucotomy studies have demonstrated that ablations of sections of the limbic system, or the association areas, reduce the severity of OCD symptoms. The direct mechanism through which this occurs is unknown. If the defective inhibitory ability in the arousal system of OCD patients, as proposed by the "alternate waking state hypothesis" put forth by Epstein and Bailine (1971) or the evoked potential deviation noted by Ciesielski et al. (1981) are correct, the effect of leucotomies may be to alter a chronically overaroused state.

A recent article by Bear (1983), equating areas of hemispheric dysfunction with specific emotional and behavioral patterns, may be useful in helping to synthesize the results of these disparate studies. Bear suggested that there are characteristic emotional patterns for temporal lobe epileptics dependent upon the involved hemisphere. Right-sided foci are characterized by an impulsive, aggressive pattern, whereas controlled, reflective profiles are typical for left-sided lesions. Left temporal lobe lesions show "ideative traits including religiosity, philosophic interests, sense of personal destiny, paranoid concerns, and hypergraphia" (Bear, 1983, p. 197). These behavioral characteristics, in many instances, are not unlike the style of OCD patients, and it is interesting to note that some EEG studies of anxiety and OCD patients have documented abnormal activity in the left temporal region (Crighel & Solomonovici, 1968; Epstein & Bailine, 1971). In addition to left–right asymmetry, Bear (1983) discussed what he refers to as complementary parietofrontal and temporofrontal systems, each with independent limbic connections and specific functions. Although the temporofrontal system is important for the processing of affective information and autonomic responses, the parietofrontal system is responsible for emotionally appropriate arousal including recognition of threat. Within this second system, there is limbic input from the cingulate gyrus to the inferior parietal lobule and back to the cingulate. It appears this circuit mediates emotional arousal and rapid selective attention to stimuli important for goal attainment. Lesions in this area could interfere with surveillance, orientation, and arousal, with deficits manifesting as neglect, apathy, or abulia (Bear, 1983). If one can speculate on overstimulation in this area, then it might be expected to lead to overconcern as opposed to neglect or apathy, and abulia might be replaced by rigidity. If this is so, the function of this system might explain the success of cingulate leucotomies in ameliorating OCD systems.

Although these studies suggest potential sites for cerebral dysfunction in OCD patients, they do not specify the mechanism by which the symptoms occur. Moreover, a recent study comparing OCD patients with normals revealed no differences in gross anatomical features (Insel, Donnelly, Lalakea, Alterman, & Murphy, 1983). However, studies designed to examine the brain at a more basic level (i.e., neuronal concentrations) will need to be conducted before definitive statements can be made. In this regard, reliance upon postmortem evaluations might be necessary.

Biochemical and Pharmacological Studies

Because mood disturbance has been noted as a feature of OCD, two biological tests used to assess for depression are worthy of note.

These are the Dexamethasone Suppression Test (DST) and sleep studies.

Dexamethasone Suppression Test

The Dexamethasone Suppression Test (DST) consists of orally administering dexamethasone (1 mg) at 11 p.m. followed by measurement of plasma cortisol levels the following day at 8 a.m. and 4 p.m. In normal individuals, plasma cortisol remains suppressed for 24 hr following dexamethasone administration. Lack of suppression of plasma cortisol levels is thought to be a biological marker of depression. The DST has been suggested as one objective diagnostic test to identify major depressive disorder (Carrol et al., 1981). Although reports regarding the specificity of the test are inconsistent, approximately 40% to 60% of the patients with major depressive disorder show a pattern of cortisol nonsuppression (>5 micrograms/dl) after administration of dexamethasone (1 mg) the previous night (11 p.m.; Carroll et al., 1981). The DST has recently been used in the assessment of obsessive-compulsive patients. The DST was administered to 16 OCD patients, 7 of whom had secondary depressive symptoms (Insel, Kalin, Guttmacher, Cohen, & Murphy, 1982). In each of the 7 cases, depressive symptoms were secondary to the obsessive-compulsive disorder. Six (37.5%) of the 16 patients treated had an abnormal DST response. This percentage is approximately equivalent to the 40-60% figure of sensitivity cited in the literature for the number of depressed individuals who fail to suppress (Brown, Johnston, & Mayfield, 1979; Carrol et al., 1981). In OCD patients, there was a trend for those patients who had higher scores on a depression rating scale, and a family history of affective illness, to be DST nonsuppressors, again suggesting the possibility of a shared biological substrate for the two disorders. In another study, Åsberg, Thorén, and Bertilsson (1982) used the DST to assess 17 OCD patients in the manner recommended by Carrol et al. (1981). Seven of the 17 patients (41%) were found to be nonsuppressors. The authors contended that some cases of melancholia and obsessive-compulsive disorder may have the same biochemical disturbance, despite the apparent differences in the clinical picture.

Sleep Studies

Sleep patterns and sleep EEG recordings of OCD patients were contrasted with those of patients exhibiting primary depression and a group of matched normal controls (Insel, Gillin, et al., 1982). Seven of the fourteen OCD patients evidenced sufficient depressive symptoms to meet DSM-III criteria for major depressive disorder. However, in all OCD subjects, appearance of depressive symptoms was subsequent to onset of OCD. Results indicated that the OCD patients differed from the normal subjects on 8 of 17 sleep variables. In comparison with the normals, the EEG "disclosed a pattern of shallow, interrupted, insufficient, and shortened sleep." (Insel, Gillen, et al., 1982, p. 1375). Of particular interest was the reduction of Rapid Eye Movement (REM) latency and Stage 4 sleep in OCD patients, similar to the pattern noted in primary depressives. There was also a reduction of REM efficiency in patients with OCD, resulting from the intrusion of NREM or awake time. Sleep pattern of the OCD patients was similar to that of depressed patients, possibly providing further evidence of a link between the two disorders. These results, however, are tempered by reports of extreme anxiety on the part of the OCD patients regarding the sleep-monitoring procedure. Of the 18 patients invited to participate in the research, four refused because of concerns about contamination. Of the remaining 14, the authors related:

> For many of the patients, particularly those with cleaning rituals, the sleep-recording procedures were a source of considerable distress. Two patients refused to allow recordings in their regular hospital bed for fear of contamination. Others insisted that they shower just before and after the sleep recordings. One patient who reluctantly consented to the sleep study withdrew after 2 nights amid intense preoccupations that the electrodes had contaminated her bed. (p. 1374)

Thus, the pattern of shallow, interrupted sleep could be attributed to either characteristics of OCD or a reaction to the sleep-monitoring procedure.

Although current research would suggest that behavioral strategies are the most effective treatments for obsessions and compulsions, drugs also play an important role in certain cases. For example, Foa (1978) reported that for at least one subcategory of OCD, attempts at remediation of obsessional behavior will be ineffective until the depressive mood has been alleviated. Thus, pharmacological intervention has been accepted as an integral component in the treatment of OCD when depression is a particularly prominent feature. In addition to the antidepressants, other drugs frequently used in the treatment of OCD include antianxiety agents and neuroleptics.

Antianxiety Agents

Because of the severe anxiety often concomitant with OCD, anxiolytic agents have been widely used. Numerous studies have demonstrated that the performance of rituals is associated with decreased levels of anxiety or discomfort caused by the obsessions (e.g., Hodgson & Rachman, 1972; Rachman, 1976; Roper & Rachman, 1976; Roper, Rachman, & Hodgson, 1973). Therefore, reduction of anxiety might be expected to correlate with reduced OCD symptoms. However, Lader (1974) demonstrated that although physiological arousal and anxiety are often confused, level of physiological arousal does not always correlate with the subjectively perceived experience of anxiety. In particular, although anxiety may initially develop as a result of an increased level of arousal, diminution of the arousal does not necessarily result in decreased subjective feelings of anxiety. For example, anxiety patients treated with diazepam evidenced a decreased level of physiological arousal but no concomitant changes in perceived level of anxiety (Lader, 1974). In addition, propanolol (a betablocker) has been found to produce reduction in physiological arousal in OCD patients (Rabavilas, Boulougouris, Perissaki, & Stefanis, 1979). However, clinical ratings of symptoms did not decrease, and patients did not report themselves as less anxious or more content when using the drug. As Ananth (1976) concluded, although certain preparations may decrease arousal levels, they are ineffective in decreasing the primary symptoms of obsessions and compulsions. Thus, it does not appear that anxiolytic agents are effective in the treatment of OCD, indicating the disorder is considerably more complex than simple increased level of arousal.

Neuroleptics and L-Dopa

Biochemical bases have been suggested for three of the final four disorders previously listed. Parkinson's Disease, schizophrenia, and Tourette's Syndrome all encompass behavior which, superficially or otherwise, resembles OCD. In these disorders the similarity pertains to the stereotypic, repetitive movements, except that the movements are assumed to be involuntary in these conditions. The hypothesized biochemical abnormality in each of the latter three conditions is aberrant dopaminergic functioning, with increased or excessive activity in the case of schizophrenia (Neale & Oltmanns, 1980) and Tourette's Syndrome (Shapiro et al., 1978) and decreased dopaminergic functioning in Parkinson's Disease (Iversen, 1977). Part of the effectiveness of neuroleptic medications is their ability to alter dopamine levels. Neuroleptics have been successfully used to treat schizophrenia and Tourette's Syndrome, and L-dopa has been found to eliminate the stereotypic and repetitive movements of Parkinson's Disease. As described, these conditions have behaviors similar to those seen in OCD. Thus, the possibility of dopamine involvement in OCD is raised. However, to our knowledge, there have been no studies investigating dopamine function in OCD.

Antidepressants

In 1977, Yaryura-Tobias proposed a serotonin hypothesis for obsessive–compulsive disorders. The serotonin hypothesis states there are decreased functional levels of serotonin available at the synaptic cleft of OCD patients when compared with normals. Among the antidepressants, the drug clomipramine, which has a potent serotonergic action component, has been reported to be particularly effective in the treatment of this disorder (Thorén, Åsberg, Cronholm, Jörnestedt, & Träskman, 1980; Yaryura-Tobias, Berbirian, Neziroglu, & Bhagavan, 1977). Ananth, Solyom, Bryntwick, and Krishnappa (1979) reported that clomipramine resulted not only in a decrease in anxiety and depression, but also a significant reduction in the severity of obsessions. Although most of the clomipramine studies suffer from methodological inadequacies including the uncontrolled nature of the clinical reports, use of mixed diagnostic groups, different dose ranges and methods of administration of clomipramine, varying duration of treatment and absence of objective measures of the primary symptoms (Turner & Michelson, 1984), the preliminary results nevertheless raise the question that neurotransmitter deficits similar to those posited in some biological theories of depression may be operating in OCD.

Because many OCD patients report feelings of depression, various antidepressants have been used in treatment. The amine hypothesis of affective disorders suggests a decreased availability of functional amines, including serotonin (5-HT) and norepinephrine (NE) in the brain, specifically at the neural synapses. Functional deficits of these neurotransmitters at the synaptic clefts have been suggested as being related to depressive states. There is evidence to suggest reduced serotonergic function in depressed patients. First, reduction in 5-HT levels or its metabolites has been noted in the cerebral spinal fluid (CSF) and blood of some depressed patients (Coppen & Wood, 1982). Similarly, a reduction has been observed in 5-HT levels in platelets of depressed patients (Meltzer, Arora, Baker, & Tricou, 1981; Tuomsito & Tukiainen, 1976). Antidepressants that affect the neurotransmitters serotonin and norepinephrine have been reported to have varying degrees of effectiveness in treating OCD. For a review of pharmacological interventions in OCD, see Ananth (1976, in press).

Of all the antidepressants, clomipramine has been demonstrated to be the most effective, with apparent antiobsessive properties discovered in an accidental fashion (Ananth, in press). The drug, being tested in depressed patients, was reported effective in eliminating secondary obsessional features. Several reviews of clomipramine as a treatment for OCD have been published (Ananth, 1976, in press; Turner & Michelson, 1984). This article highlights the biochemical mechanisms that have been implicated as being responsible for its treatment efficacy.

Similar to the action of other antidepressants, clomipramine's action is thought to hinge on its ability to block the reuptake of certain neurotransmitters. The particular effectiveness of clomipramine in OCD treatment in comparison with other antidepressants has been linked to its preference for blocking serotonin reuptake, especially when administered intravenously. Clomipramine is a potent inhibitor of serotonin (5-HT) reuptake, with a lesser, but concurrent effect on norepinephrine (Waldmeier, Baumann, Grungrass, & Maitre, 1976). This is in contrast to other antidepressants (e.g., imipramine and amitriptyline) that are less selective for serotonin. Selectivity of clomipramine for 5-HT reuptake, coupled with its clinical effectiveness in reducing symptoms of OCD, could indicate a 5-HT disturbance in obsessive–compulsive disorder, which is the basis of the serotonin hypothesis discussed earlier (Yaryura-Tobias, 1977). In a test of the serotonin hypothesis, Yaryura-Tobias et al., (1977) examined blood serotonin levels in drug-free OCD patients and controls. Twenty patients diagnosed as suffering from obsessive–compulsive disorder and 11 normal control subjects recruited from the clinic staff participated in the research. In the first part of the study, baseline blood 5-HT and urinary 5-hydroxyindoleactic acid (5-HIAA) levels were collected. The OCD patients had significantly lower levels of blood serotonin, and there was no significant difference in urinary excretion of the serotonin metabolite 5-HIAA. This suggests some disturbance in the synthesis of serotonin in OCD patients. In the second part of the experiment, OCD patients were administered clomipramine, 50 mg twice daily for 2 weeks. Blood and urine levels were collected again at the end of this period. In addition, clinicians rated improvement in symptoms at posttreatment. Following treatment with clomipramine, there was a further significant decrease in 5-HT, but no change in urinary 5-HIAA levels. The authors suggested this further reduction in 5-HT levels, but stable 5-HIAA excretion, could be explained by increased circulating levels of 5-HT being rapidly oxidized in the blood. Other studies also reported improvement in obsessional symptoms to be positively correlated with increased levels of clomipramine in the blood plasma, indicating increased availability for synthesis (Insel, Murphy, et al., 1983; Stern, Marks, & Mawson, 1980). In addition, the antiobsessional effect of clomipramine was reported to be significantly correlated with decreases in the levels of the serotonin metabolite 5-HIAA in the CSF, once again suggesting increased availability of serotonin for synthesis (Åsberg et al., 1982). The evidence provided by these investigations, including differing baseline serotonin levels, further decreases in blood platelet levels as a result of blocked reuptake, and decreased obsessions, lend support for the role of the serotonergic neurotransmitter system in OCD.

Depletion of CNS 5-HT in laboratory animals may provide evidence for a model of behavior associated with decreased serotonergic transmission. In cats, decreased availability of 5-HT by reserpine reduces 5-HT storage by acting on the storage vessicles and allowing increased intracellular catabolism, thus interfering with Stage-II sleep and reduction in REM efficiency (Jouvet, 1978). In Insel, Gillin, et al. (1982), OCD sleep study, Stage-II sleep and decreased REM efficiency were two of the variables found to differ between OCD patients and normals. In addition, serotonergic depletion in animals has been demonstrated to be related to stereotypic, repetitive behaviors. As one example, Abel (1974) administered p-chlorophenylalanine (p-CPA) which selectively depletes cerebral 5-HT in rats. Following administration of p-CPA, he observed hyperaggressivity and compulsive sexual activity in the males. He reported similar behavior in cats and rabbits. Abel (1974) hypothesized that 5-HT pathways may exert an inhibitory influence over sexual behavior, although it remains unclear if this is a result of an increase in general arousal or a direct effect on the mechanism of sexual behavior. Additional evidence to suggest that serotonergic neurons might play a role in limitation of behavior is provided by Shillitoe (1970). Depletion of 5-HT by p-CPA was associated with excessive grooming behavior in rats to the point where they experienced total baldness. Although admittedly speculative, there appears to be some evidence of behavioral repetition in rats correlated with changes in levels of the neurotransmitter serotonin. The behaviors previously described are clearly reminiscient of behavior seen in OCD.

Further clinical studies using clomipramine have provided some support for the serotonin hypothesis. Thorén, Åsberg, Bertilsson, et al. (1980) examined CSF levels of 5-HIAA (a serotonin metabolite), homovanillic acid (HVA; a dopamine metabolite), and a noradrenergic metabolite 4-hydroxy-3 methoryphenyl glycol (MHPG) in OCD patients before and after treatment with clomipramine. It should be noted that this study examined CSF levels of 5-HIAA and not urinary excretion levels as in the Yaryura-Tobias et al. (1977) study. CSF levels are thought to be a more direct indication of CNS activity. Twenty-four patients diagnosed as suffering from obsessive–compulsive disorder and 37 paid, healthy volunteers participated in the study. OCD patients were treated with one of three medications: clomipramine, 50 mg three times per day; nortriptyline, 50 mg twice daily; or a placebo. Treatment lasted for 6 weeks. Lumbar punctures were performed at pre- and posttreatment. Prior to treatment, mean concentrations of CSF 5-HIAA and CSF HVA did not differ between the OCD and control group. The level of CSF MHPG was more variable within the OCD group than the controls; 5 of the patients had higher levels of MHPG than any of the controls. In the nortriptyline group, treatment resulted in reduction in MHPG levels. After treatment with clomipramine, there was a significant reduction in both 5-HIAA and MHPG levels in the CSF and a slight but significant increase in HVA. In addition, there was an inverse relation between 5-HIAA and HVA levels; the more 5-HIAA decreased, the more HVA increased. With nortriptyline both levels increased, indicating that these two pharmacological agents differ in their effect on serotonin and dopamine receptors. This study also examined clomipramine responders and nonresponders. Responders were differentiated by significantly higher pretreatment levels of both CSF HVA and CSF 5-HIAA, whereas MHPG did not differ between these two groups. There was a significant negative correlation between 5-HIAA level during the fifth week of treatment and obsessional symptom scores, indicating those patients with a marked reduction in 5-HIAA were the ones who improved clinically. There was also a significant negative correlation between plasma concentrations of clomipramine and reduction in scores on the Leyton Obsessional Inventory.

In contrast to 5-HT pretreatment differences found in blood platelets in the Yaryura-Tobias et al. (1977) study, CSF pretreatment levels of 5-HIAA, HVA, and MHPG in the Thorén, Åsberg, Bertilsson, et al. (1980) study did not differ between OCD patients and healthy controls. However, high pretreatment CSF 5-HIAA levels in the Thorén, Åsberg, Bertilsson, et al. (1980) study were correlated with improvement in obsessional behavior. They noted that there may be some evidence for biological subcategories of OCD similar to those proposed in the depression literature (cf. Depue & Monroe, 1978). They further noted that in depression there is a bimodal distribution of CSF 5-HIAA levels, and these two modes are representative of two distinct biological subgroups. Although the small sample size of this study with the OCD patients prevents the drawing of a similar conclusion with respect to OCD, the distribution of 5-HIAA CSF levels appears similarly bimodal. Therefore, there may be subclasses of OCD patients with different biological underpinnings that may lead to differential responsivity to treatment. Thorén, Åsberg, Bertilsson, et al. (1980) suggested this may explain why the high 5-HIAA group was more responsive to clomipramine. Finally, there was a U-shaped dosage response curve in which plasma drug levels below or exceeding 300n mole/L resulted in decreased effectiveness. One explanation for this is that above this level clomipramine may begin to block serotonin receptors in addition to blocking reuptake. On the basis of all the evidence, the authors concluded that the strong correlation between reduction in CSF level of 5-HIAA and diminution of obsessive symptoms is indicative of an antiobsessive effect of clomipramine, and that this effect is related to its capacity to inhibit serotonin reuptake.

Further evidence of a role for serotonin in OCD is supported by research showing the 5-HT precursor amino-acid, L-tryptophan to be effective in treatment of OCD (Yaryura-Tobias & Bhagavan, 1977). Administration of this precursor is an alternative approach to clomipramine treatment in increasing steady-state levels of serotonin. Synthesis of serotonin is regulated by the amount of available L-tryptophan. Thus, increasing the precursor should result in an increase in the availability of serotonin for synthesis. Seven obsessive-compulsive patients were treated with 3 to 9 g of L-tryptophan in divided doses. Although criteria for improvement were not described, patients were reported to evidence considerable improvement after 1 month on the medication, and they continued to improve for up to 5 months afterward.

In summarizing the response to pharmacological intervention in obsessive-compulsive disorders, there appears to be some basis for a serotonin hypothesis. Differences in 5-HT blood plasma levels between OCD patients and normals and more variable CSF levels of MHPG within the OCD patient group have been reported. A high pretreatment level of 5-HIAA in one study was predictive of responsivity to clomipramine treatment. In addition, the decrease in CSF 5-HIAA and blood plasma 5-HT levels after clomipramine treatment indicates that increasing available levels of serotonin are correlated with a decrease in symptoms. However, thus far the biochemical evidence for this hypothesis is limited to peripheral measures of bioamine activity. Cerebral spinal fluid and blood and urine assessments are not without limitations. Exact relations between these peripheral measures and brain concentrations of the same substances have yet to be established. However, CSF metabolite concentration is considered to approximate more accurately brain concentration levels. Even if the levels were identical, there is no evidence to suggest neurotransmitter function is the same at both sites (Green & Costain, 1981). If the exact relation of peripheral neurotransmitter levels to CNS functioning was understood, this still would not clearly delineate their role in the pathogenesis of OCD. Differences in levels may be pathogenic factors, or they may be secondary effects of the disorder and have no role in causality.

Despite the existence of some evidence for the role of serotonin in obsessive–compulsive disorders, there are difficulties in validating the hypothesis with current approved antidepressive drugs. The reason for this is that clomipramine and other widely used antidepressants also have an effect on the neurotransmitter norepinephrine. Hence, norepinephrine and serotonin are affected when these drugs are used. The clomipramine metabolite, demethylclomipramine, has been demonstrated to have effects on norepinephrine. Thus, the effect of clomipramine cannot entirely be attributed to its effect on serotonin. In a recent study using zimelidine, a specific serotonin blocker that has been withdrawn from use by the Food and Drug Administration, and desipramine (which preferentially inhibits norepinephrine reuptake), Insel and Mueller (1984) reported that neither zimelidine or desipramine had a significant effect on clinical ratings of obsessionality in 13 OCD patients. However, when these patients were treated with clomipramine, they showed significant improvement on a global obsessional scale. The authors noted that CSF 5-HIAA did not significantly differ between zimelidine and clomipramine treatment. This indicates the ineffectiveness of zimelidine (a selective serotonin blocker) when compared with clomipramine (a serotonin and norepinephrine blocker) and raises questions regarding a singular central role for serotonin in OCD. Of course, these data are preliminary, and further studies with other antidepressants selective for serotonin (e.g., fluoxetine) will be necessary to delineate more explicitly the possible role of serotonin in OCD.

Summary and Discussion

It is clear from the previous discussion that we are not at a point where an integrated biological theory of OCD can be proposed. Although the findings reviewed here consistently suggest that biological factors are correlated with OCD, a truly integrated discussion of these findings would be premature. From the data discussed, it does not appear that OCD is strictly a biological abnormality. Rather, the data suggest some type of biological predisposition that leaves an individual more vulnerable to the development of OCD, perhaps as a result of psychological stress.

The high concordance rate observed in monozygotic twins as opposed to dizygotic twins is comparable with concordance rates obtained in studies of schizophrenia and seems to suggest some type of genetic transmission. However, the absence of adoptive studies makes it impossible to rule out psychogenic or environmental factors. Moreover, the data that are available do not support a straightforward genetic model. It may well be that what is inherited is the tendency toward chronic elevated arousal or a tendency to respond in an overaroused fashion. It has long been noted that neurotic patients are subject to chronic overarousal which has been referred to as anxiety proneness (e.g., Carey & Gottesman, 1981). There is also some evidence that such individuals demonstrate resistance to habituation. In fact, Eysenck (1979) described a tendency for vulnerable individuals to show increases in arousal on repeated presentation of feared stimuli rather than extinction. This is known as the incubation effect or paradoxical enhancement of anxiety. If OCD patients are congenitally overaroused, this might explain their tendency to worry excessively and to overrespond to threatening stimuli, and the ability of such stimuli to elicit anxiety responses. In vulnerable individuals, such a process could be set off under circumstances such as the stress of giving birth or interpersonal conflict.

These significant events have been noted to be related to onset of OCD (Turner & Michelson, 1984). In a diathesis-stress model such as the one just described, the nature of psychological stress would determine the particular symptomatic expression in each individual. A recent study by Torgersen (1983) also provides evidence for genetic transmission of proneness to anxiety. Torgersen studied a subsample of 32 MZ and 53 DZ adult twins of the same sex who were part of a nationwide study of neurotic and borderline psychotic adult same-sex twins treated in Norway during the 1970s. The study was reported to have included almost all adult same-sex twin patients born between 1910 and 1955 and who were admitted to an institution before 1977. Two hundred and ninety-nine pairs were personally interviewed. In 19 pairs, both twins were probands. Therefore, the total number of probands was 318. Among the findings reported by Torgersen was that no MZ twin had the same disorder as the corresponding proband. That is, the MZ twin had a high incidence of anxiety disorder but not necessarily the same disorder as the proband. The concordance for an anxiety disorder in the twin was higher in MZ than in DZ pairs in all the twin proband groups except generalized anxiety. These data lend further support for a genetic transmission of anxiety proneness rather than a specific anxiety disorder.

One caveat with respect to the genetic studies is in order. In examining these studies, caution is advised because of differential diagnostic procedures used to determine anxiety disorders. As we noted, it is unclear in some of the studies whether the symptoms manifested by first-degree relatives were true obsessive–compulsive disorder symptoms or compulsive personality characteristics. A distinction has been made based on this dichotomy (Slade, 1974).

As was previously discussed, the findings from neuropsychological and neurophysiological investigations and studies of the effects of leucotomies suggest possible neuroanatomical abnormalities in OCD. These aberrations include altered EEG patterns, differences in averaged evoked potential, and suggestions of dominant frontal lobe dysfunction. However, all of these studies have major methodological difficulties including small sample size, lack of comparison groups, and lack of information regarding base rates for these abnormalities in the general population. In addition, psychosurgical procedures involving lesions in certain sites have been shown to reduce symptoms of OCD. These results also point to an organism that is in a chronically overaroused state.

Serotonin has been the subject of considerable study in relation to OCD. Clinical studies of the antidepressant clomipramine have been used to support the role of serotonin. However, the major flaw in all of these studies is that they do not have adequate measurement of OCD behaviors. In particular, there are no direct measures of obsessions and compulsions per se. Thus, it is difficult to assess the antiobsessive effect independent of mood. Moreover, the best designed study using the most sophisticated assessment strategy failed to reveal an antiobsessive effect for clomipramine. Rather, the effect was found only on measures of mood (Rachman et al., 1979). Biochemical abnormalities are found not only in studies of serotonin level, however. Recent reports have suggested that OCD patients also exhibit differing levels of norepinephrine when compared with normals. Thus, at this juncture, it is impossible to suggest a single biochemical factor as responsible for the disorder.

In view of the evidence presented, it would appear premature to attempt an explanation of OCD based on a single etiological hypothesis. It is possible that genetic predisposition, neuroanatomical involvement, and biochemical abnormalities (including serotonin and norepinephrine) may contribute to the pathogenesis of obsessive–compulsive disorders, each in varying degrees. It is also possible that the manifestations seen in these various systems are reflective of the same pathological process. The one unifying theme is that the disturbance in these systems is related in some way to emotional overarousal. Finally, it was also noted that a diathesis-stress model is called for to explain fully the current findings. At present, we know little about the complex interaction of these biological and environmental factors.

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Summary and conclusions

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History and treatment

'I know it's stupid; I feel like a crazy person, yet I know that I am not crazy!' This is a typical statement from a patient suffering from obsessive-compulsive disorder (OCD) who has spent over six hours each day for the past ten years washing her hands, despite recognising its senselessness. Other patients are compelled to check and recheck for hours each day whether or not the stove is off or the doors locked. An internist calls the laboratory 15 times to confirm that he has heard the white cell count correctly. A pathologist cannot be sure that a slide does not reveal mycobacteria or that the edges of a surgical specimen are free from tumour cells, even after hours of viewing. Other patients endure endless hours of obsessive, intrusive thoughts each day. Careers come to an end and families disintegrate as a result of this often unrecognised, but usually treatable illness. Since it often begins in childhood (as early as two years of age) or in early adulthood (mean age of onset 20–22 years) and rarely remits without specific treatment, patients may suffer lifelong disability (JENIKE, 1989). Recent research suggests that OCD may well be more of a neurological illness than a psychiatric disorder. Professor Åsberg noted Carl Westphal's contribution to our understanding of these disorders – including trichotillomania, which has recently been rediscovered as a common entity responsive to pharmacotherapy and behavioural techniques. The early enthusiasm of psychoanalysts in seeking a cure for OCD led to disappointment and the realisation that psychodynamic psychotherapeutic approaches, although interesting, did not resolve symptoms. Åsberg reviewed early work demonstrating the efficacy in some patients of behavioural techniques – exposure *in vivo* with response prevention – and the controlled trials of clomipramine, which demonstrated its superiority over placebo and other tricyclic compounds. Concomitant affective symptomatology predicted a favourable response to clomipramine but was not a prerequisite for its effective action in OCD; even non-depressed patients improved, a finding confirmed in many later studies. Professor Åsberg concluded by noting that response to clomipramine may implicate the brain's serotonergic system in the pathophysiology of the disorder, and that OCD may be a heterogeneous condition with causes ranging from organic or neurological to biochemical disturbances.

Epidemiology of OCD

Professor Rasmussen showed how common OCD really is. Once considered a rare disorder, it is now known to be one of the most common psychiatric disorders, with a lifetime prevalence of 1–2% of the population. Current estimates of prevalence are 50–100 times higher than earlier predictions, with rates double those of panic disorder and schizophrenia.

How could a disease be so prevalent and remain hidden from physicians? Possible reasons are that most patients are seen by non-psychiatric health professionals who may be unfamiliar with the disorder, and that patients are reluctant to elaborate on symptoms which they view as crazy or unique. Even spouses may be unaware that their mate is spending hours performing rituals each day. Freud's explanation (quoted in RAPOPORT, 1989) was that 'Sufferers from this disorder are able to keep their affliction a private matter. Concealment is made easier from the fact that they are quite well able to fulfil their social duties during a part of the day, once they have devoted a number of hours to their secret doings, hidden from view.' The need for medical vigilance is illustrated in a recent study (RASMUSSEN, 1985), in which 37% of patients presenting to a dermatology clinic with non-specific dermatitis had OCD, although none had ever sought treatment for it. It is recommended that screening questions for OCD should be a routine part of every mental status examination, especially in anxious and/or depressed patients.

Studies of the genetics of OCD have shown that about 25% of first-degree family members of patients also have OCD, and that another 15% have features of the illness; there was also a significantly increased incidence of multiple tics.

Social aspects of OCD

The social consequences of OCD can be very severe. Some patients can only focus on their obsessive concerns and withdraw from work, family and friends. Family life can be severely disrupted if the patient loses his or her job, with a resultant loss of income. Professor Burrows noted the importance of including relatives in the treatment plan – all OCD patients attempt, often very successfully, to get family members to perform rituals in an effort to keep the patient 'happy'.

Professor Burrows presented an overview of behavioural treatments and pharmacological approaches in OCD, noting that the success rate is quite high considering the disabling nature of the symptoms. Maximum therapeutic benefit is often not evident until after 10–12 weeks on an effective drug.

Neurobiology of OCD

Some of the most exciting work over the last five years has involved investigations combining sophisticated neuropsychological techniques and high technology. Professor Rapoport reviewed some of the data suggesting that the basal ganglia and frontal lobes may be aetiologically important in OCD.

The serotonergic theory derives from two convergent lines of evidence. Firstly, drugs known to have potent effects on the serotonergic system, such as clomipramine, are effective in treating OCD, while less potent serotonergic agents are not helpful. Secondly, recent studies using the serotonergic agonist mCPP suggest that clomipramine works by downregulating serotonergic responsivity. A major problem with this hypothesis is that desmethylclomipramine, the main metabolite of clomipramine, is a potent noradrenergic reuptake blocker, and thus clomipramine is not a purely serotonergic drug but a more complex drug with effects on other neurotransmitter systems including histamine and dopamine. The dopaminergic system is also potentially implicated by the considerable clinical overlap of OCD with Tourette's syndrome, though effective treatment for these two disorders is usually quite different.

Professor Rapoport next reviewed aspects of neuroendocrine dysfunction in OCD. Several studies from the National Institute of Mental Health have found an exacerbation of OCD symptoms during early puberty, with some female patients experiencing increased symptoms immediately before their menses; a controlled study is currently under way to evaluate this relationship. Antiandrogen treatment has produced remission of OCD in five patients. The different incidence of OCD before and after puberty could be due to the effects of an androgenic hormone.

Recent research has implicated the basal ganglia in OCD. Patients who developed von Economo's encephalitis in the early part of this century sometimes suffered symptoms remarkably similar to OCD; at autopsy, lesions in the basal ganglia were found. Tourette's syndrome, also believed to involve the basal ganglia, is well known to be associated with OCD. Other researchers have demonstrated a high prevalence of tic disorders in OCD patients who do not have Tourette's syndrome. Sydenham's chorea is another basal ganglia disorder associated with a high prevalence of OCD. Surgical lesions which sever the connections between the frontal lobes and basal ganglia are sometimes therapeutic. Careful CT scanning has found the caudate nuclei in OCD patients to be smaller than in controls. As assessed by PET, there is increased metabolism in the caudate nuclei and frontal lobes of OCD patients compared to controls.

In conclusion, Professor Rapoport set out a model of how the basal ganglia and frontal lobes might be involved in the production of OCD symptoms. Such models need to take into account the episodic and variable nature of symptoms, not only from patient to patient but within the same patient over time.

Management of the patient with OCD

Some 90% of patients with OCD can be helped by serotonin reuptake blockers and behaviour therapy, either used alone or, more commonly, in combination. Professor Greist noted that behaviour therapy – exposure and response prevention – is extremely effective, especially for patients with overt rituals, and should be offered to all patients with persistent symptoms. Behaviour therapies are still not widely used in psychiatry, partly because they are labour-intensive and because most clinicians lack the relevant training and experience. Recent techniques, however, emphasise less frequent medical visits and focus on home treatment, with patients performing homework by themselves or with the help of selected family members.

Good results have been obtained with the newer anti-obsessional medications. By far the best studied is clomipramine, with at least 12 carefully controlled double-blind trials confirming its efficacy against placebo and other antidepressants. New medications such as fluvoxamine and fluoxetine are currently under investigation, and preliminary evidence suggests that they are also effective.

It is important to remember that, on average, symptoms are reduced by around 30–40% with drug therapy; although significant symptoms remain, the majority of patients feel much better. When combined with behaviour therapy, up to 90% of patients improve. Relapse after withdrawal of medication is usual; however, few of the patients who relapsed in the two reports to date had received behaviour therapy. It is likely that behaviour therapy may not only enhance the response to medication but may also lower relapse rates.

Finally, Professor Greist discussed psychosurgical procedures for severely disabled patients with treatment-resistant OCD, and concluded that surgery does have a part to play in overall management.

Clomipramine as an effective treatment for OCD

Dr DeVeaugh-Geiss presented data from three multicentre studies in the USA comparing clomipramine to placebo. Two of the studies were conducted at 21 centres and involved adults only; the third study was conducted at five centres and involved children and adolescents aged 10–17 years.

A total of 520 adults and 60 children and adolescents were studied; about half received clomipramine and half placebo. A very low rate of placebo response was found (4–5%). Patients who received clomipramine improved by 35–42%, representing not only statistical significance but clinically relevant improvement as well. Clomipramine was well tolerated in doses up to 250 mg daily.

PET studies in patients undergoing capsulotomy

Noting earlier work showing increased metabolic rates for glucose (as assessed by PET scanning) in patients with OCD, Dr Mindus used similar techniques on five patients with chronic, intractable, and incapacitating OCD who underwent capsulotomy. This procedure, which is effective in reducing OCD symptoms, is performed by interrupting fibres in the anterior limb of the internal capsule, a procedure believed to remove direct interconnections between the frontal lobes and the limbic system. PET scans, done ten days prior to and 12 months after capsulotomy, confirmed previous reports of disordered metabolism in the frontal lobes and caudate. Interestingly, the preoperative scans found the opposite of previous scans – a *lower* metabolic rate compared to healthy controls.

In an attempt to explain these contradictory findings Dr Mindus suggested that his patients were more severely and chronically incapacitated than patients in earlier studies, and that they were refractory to conventional therapy. In contrast, patients in earlier studies had been ill for a shorter period of time, all were outpatients, and most responded later to conventional medications. Perhaps the increased metabolic activity represents a relatively acute process while more chronic 'burned out' patients show decreased activity. This is a testable hypothesis.

What is the spectrum of OCD?

Our knowledge of OCD has grown rapidly over the last few years (JENIKE et al, 1990), but a number of major problems remain. It is unclear what disorders should be included within the category of OCD. Many illnesses can present with frank obsessive-compulsive symptoms – Tourette's syndrome, schizophrenia, major depressive disorders, and organic mental disorders. In these cases the obsessions and compulsions are presumed to be secondary to the primary illness. There are also a few syndromes whose symptoms are so similar to OCD that diagnostic distinctions are not always clear; in these cases treatments similar to those employed in OCD have often been successful. These syndromes include trichotillomania, non-symptomatic hypochondriasis, dysmorphophobia, globus hystericus, bowel and urinary obsessions, compulsive face-picking, and fear of acquired immunodeficiency syndrome (AIDS). Many patients with eating disorders, besides being obsessed with food, also have obsessive-compulsive rituals such as repetitive hand-washing. Some patients who mutilate themselves may do so primarily to relieve anxiety, and may therefore be considered to have OCD.

In DSM-III-R, a number of related disorders are classified as impulse control disorders – kleptomania, pathological gambling, pyromania, and trichotillomania. Perhaps compulsive shopping and severe nail-biting should also be included in this category.

Whether these disorders are related in some fundamental way to OCD is not yet clear: a better understanding of their pathophysiology is required. The finding that many of them, including trichotillomania, respond to serotonergic drugs such as clomipramine, but not to adrenergic agents such as desipramine, suggests similarities. Whether habits like nail-biting, face-picking or smoking will respond to serotonergic agents remains to be seen.

Recognition of these disorders in medical practice is particularly important since effective treatments are available. Understanding their pathophysiology will not only benefit patients, but may also shed light on the biology of certainty, doubt, motivation and satisfaction.

What is the relationship between OCD and obsessive-compulsive personality disorder?

A persistent area of confusion among clinicians concerns the relationship between OCD and obsessive-compulsive personality disorder (OCPD). Often viewing them as the same disorder, clinicians attempt treatments that are unlikely to succeed. For example, although traditional psychodynamic psychotherapy produces little change in the obsessions and compulsions of OCD, it may be of some value in patients with OCPD. Conversely, although behaviour therapy and anti-obsessional medication have been shown in controlled trials to be very effective in OCD, there is no evidence that they are helpful in OCPD.

Having similar names adds to the confusion between these two *distinct* diagnostic entities. In European psychiatry the adjective anankastic is still used to describe the obsessional personality, probably because it is helpful to have a separate word to distinguish obsessional personality from OCD.

Furthermore, in DSM-III-R, OCD is listed as a complication of OCPD, along with major depression and dysthymia, suggesting that OCPD patients may develop OCD as a complication in much the same way as they become depressed or dysthymic. OCD is not listed as a complication of any other personality disorder in DSM-III-R, suggesting that OCD and OCPD are in some way fundamentally related or that one may lead or predispose to the other.

Currently there is no evidence that OCPD patients are more likely to develop OCD than patients with any other personality disorder. Further confusing the issue is the fact that a few patients meet the criteria for both OCD and OCPD.

OCD in the elderly

There is almost nothing written about OCD in the elderly. Data from the Massachusetts General Hospital OCD clinic and research unit showed that only one of 100 consecutive outpatients had *onset* of the disorder after the age of 50. However, reviewing data from a later group of 183 consecutively evaluated patients, showed that 22 (12%) were over 50 when first seen at the clinic, and eight (4%) were 60 or older. Thus the percentage of elderly patients is not insignificant. Many had never received treatment and, of those who had (some for decades), most had never received proper treatment. The majority of these elderly patients were markedly improved after a few months of appropriate treatment, usually behaviour therapy and psychotropic medication.

Serotonin and OCD

Some of the work implicating serotonin in the pathophysiology of OCD has been reviewed in this volume. Over the next decade, new and more specific probes (both agonists and antagonists) for each type of serotonergic receptor are likely to become available. Two serotonergic receptors have already been cloned and their structure described. As Professor Rapoport said, the question is no longer 'Does OCD represent a neuropsychiatric disorder?' but rather

'What is the site and nature of the lesion?' This indicates the direction that research is likely to take over the next decade.

Better treatments, and predictors of response and relapse

Today's drugs are very much more powerful and effective than older agents in the treatment of OCD. In general, however, patients still only improve by 30–40%, over 15% do not respond to medication at all, and we cannot predict which patients will respond to which medication. The use of a second medication to enhance or augment a partial response to a primary anti-obsessional drug may become more common in future, but to date there are only anecdotal reports; placebo-controlled trials are lacking.

More data on the efficacy of the various types of neurosurgical procedure for OCD are required, as are better data on relapse rates following discontinuation of drug therapy; currently these range between 25 and 90%. The possible protective effect of behaviour therapy against relapse has not been studied.

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The Obsessive-Compulsive Foundation

Over three years ago a group of OCD patients started the OC Foundation (PO Box 9573, New Haven, CT 06535, USA), which today provides referral recommendations and advice to sufferers around the world. Patients can contact the Foundation directly to find out about local clinics that specialise in obsessive-compulsive and related disorders. Their newsletter keeps patients and physicians informed of new developments.

Cognitive-Behavioral and Pharmacological Treatments of Social Phobia

A Controlled Study

Cheryl Shea Gelernter, PhD; Thomas W. Uhde, MD; Peter Cimbolic, PhD; Diane B. Arnkoff, PhD;
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• Sixty-five patients with social phobia were treated in a study that compared a cognitive-behavioral group treatment program with pharmacotherapy with alprazolam, phenelzine sulfate, or pill-placebo plus instructions for self-directed exposure to phobic stimuli. Statistically significant repeated-measures effects were shown on all measures, indicating that the treatments studied were associated with substantial improvements in patients with severe and chronic social phobia. Patients who were treated with phenelzine were rated by clinicians as more improved on a measure of work and social disability than patients who were treated with alprazolam or placebo (patients in the cognitive-behavior therapy group were not rated on this measure). Subjects showed positive cognitive changes from before to after treatment, and there were no differences between treatment groups on the cognitive measure. We discuss the implications of these findings within the context of demographic and clinical predictors of response.

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Although social phobia was classified as a discrete syndrome more than 20 years ago,[1,2] it was not until 1980 that the American Psychiatric Association formally recognized social phobia as a discrete diagnostic entity.[3] During the last decade, reviewers of the social phobia literature have noted that this syndrome is among the least studied of the major anxiety disorders and have called for further research to address gaps in our knowledge concerning definition, prevalence, etiology, pathophysiology, assessment, and treatment.[4-6] In their review of the social phobia literature, Liebowitz et al[6] observed that this disorder has not been viewed by psychopharmacologists as a distinct syndrome worthy of independent study. Consequently, there are few controlled evaluations of treatments of social phobia.

The drug that has been most studied for the treatment of social phobia is the monoamine oxidase inhibitor phenelzine sulfate; four controlled drug trials have been conducted that evaluated its effectiveness[7-10] in treating patients with mixed or unspecified phobic conditions. The results of these early drug studies hinted at possible phenelzine efficacy for social anxiety, but limitations in the design of these studies made it difficult to reach definitive conclusions regarding the therapeutic benefits of monoamine oxidase inhibitor medications in the treatment of social phobia. Specifically, these older studies treated mixed samples of phobic patients, including patients with social phobia and agoraphobia, and the results were not reported by diagnosis, making it impossible to determine whether the patients with social phobia, as a separate group, improved at all. These investigations suggested a need for future studies with well-defined subject samples, adequate medication dosages and treatment duration, more comprehensive assessments, and well-controlled, double-blind designs.

Two later trials of phenelzine in samples of patients with pure social phobia yielded additional data that supported the efficacy of phenelzine for treatment of these patients. The first, an open pilot study, found that all patients who were treated with phenelzine achieved moderate to marked improvement.[11] The second study has been the only well-controlled investigation of phenelzine in a sample of patients with pure social phobia reported to date. In this latter study, Liebowitz and colleagues[12] published an interim report of a double-blind, placebo-controlled comparison of phenelzine and atenolol, a β-adrenergic blocker, in a sample of patients who met *DSM-III* criteria for social phobia. Preliminary data from this ongoing study have suggested that phenelzine, but not atenolol, may be an effective treatment of social phobia. However, these findings should be interpreted con-

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servatively, given the interim nature of the report and the presentation of only selected results from newly developed outcome measures.

Data regarding benzodiazepine treatments of social phobia are minimal. Although case reports[13] and open clinical trials[14] have suggested that alprazolam, a triazolobenzodiazepine useful in the treatment of panic disorder,[15,16] reduces social anxiety, no controlled study investigating the effectiveness of alprazolam has been conducted for social phobia.

Considered together, these data suggest possible phenelzine and alprazolam efficacy with social phobia. However, given the disparate patient population in the older studies and the preliminary nature and/or relatively small sample size of more recent trials, the value of these agents (ie, phenelzine and alprazolam) as treatments of pure social phobia remains to be established.

Relatively few studies of cognitive-behavioral therapies in clinical populations of patients with social phobia have been conducted. The research in this area has focused on the efficacy of cognitive restructuring and exposure techniques, applied in isolation or as a part of a multicomponent treatment package. Results of these clinical studies have suggested that cognitive restructuring and exposure interventions are effective in the treatment of social anxiety.[17-25] However, no investigation has been conducted to establish the relative efficacy of cognitive-behavioral strategies and pharmacological approaches to the treatment of social phobia. The present investigation addressed this question by comparing the effects of a cognitive-behavioral group treatment with pharmacotherapy (phenelzine, alprazolam, and pill-placebo) plus instructions for self-directed exposure to phobic stimuli. To our knowledge, this is the first methodologically rigorous investigation that compares pharmacotherapies for social phobia and the first controlled study that compares two pharmacotherapies with psychotherapy for this disorder.

PATIENTS AND METHODS

The majority of the patients who participated in this investigation were selected from a pool of respondents to a newspaper article in the "Health Section" of the *Washington Post* that described social phobia and a research program for its treatment at the National Institute of Mental Health, Bethesda, Md. Others came from a variety of referral sources, including other units at the National Institute of Mental Health and private practitioners. To be considered for participation, subjects had to be aged 18 to 60 years, free of medications, or able to discontinue any medications other than oral contraceptives, and willing to accept random assignment to treatment in a double-blind procedure. Prospective patients were sent a screening packet that contained a brief description of the program and two screening measures for social phobia. Treatment applicants who reported subjectively distressing levels of social phobic anxiety and avoidance on either of the screening measures, ie, the Social Phobia Subscale of the Fear Questionnaire[26] and the Social Avoidance and Distress Scale,[27] were prescreened via telephone by one of us (C.S.G.). Eligible candidates for the treatment program were invited to the National Institute of Mental Health for a structured diagnostic interview.

In the next phase of the screening process, the patients were evaluated by one of two clinical psychology doctoral candidates with the use of the Anxiety Disorders Interview Schedule–Revised[28] and a modified form of the Schedule for Affective Disorders and Schizophrenia–Lifetime version.[29] Criteria for inclusion were a primary diagnosis of social phobia by *DSM-III* criteria and good physical health. Criteria for exclusion were (1) *DSM-III* diagnosis of major depression, melancholic subtype; (2) pregnancy or the intention to become pregnant during the 6 months of the study; (3) a history of psychosis; (4) an active substance abuse problem; (5) presence of a medical condition that would contraindicate treatment with alprazolam or phenelzine; and (6) an inability to comply with rigorous protocol requi[illegible]ments, including drug and dietary restrictions. Patients were [illegible] permitted to be in concurrent psychotherapy while they we[illegible] participating in this protocol.

Sixty-five patients were admitted to the active phase of the study, and 59 completed the treatment program and the follow-up assessment. Forty-eight patients (74%) had chief complaints of anxiety and avoidance of specific social situations. Seventeen patients (26%) complained of more generalized and pervasive social fears. Patients were classified as having specific social phobia if their main fear (the phobic situation for which they sought treatment) involved one or two of the following activities: public speaking, eating in public, writing while they were being observed, or using a public rest room. Those patients who reported fears of interacting in most social situations were designated as having generalized social phobia. This subtyping is consistent with *DSM-III-R* criteria. Differences among the treatment groups in distributions of these fears were not significant.

The sample comprised 24 men (37%) and 41 women (63%), with a mean age of 36.5 years (SD, 9.6 years; age range, 18 to 60 years). Fifty-nine patients (91%) were white, and six (9%) were black or other minority. There were 32 married patients (49%), 29 single patients (45%), and four divorced or widowed patients (6%). Forty-two patients (64%) had at least a college education, with 16 patients (24%) having also completed graduate or professional training. Fourteen patients (22%) had completed some college, and seven patients (11%) had completed no higher education after high school. Two patients (3%) had not completed secondary school. Forty-eight patients (74%) were employed full-time, and five patients (8%) worked part-time. Twelve patients (18%) were not employed. There were no statistically significant differences among treatment groups on any of t[illegible] demographic variables by χ^2 test results.

Although 27 patients (42%) had a history of major depression, only nine patients (14%) had affective disturbances (ie, dysthymic disorder) at the time of this study, and no patients currently met criteria for major depression. Several patients, however, met criteria for an additional *DSM-III* anxiety disorder, including generalized anxiety disorder (n = 19 [29%]), panic disorder (n = 3 [5%]), and panic disorder with agoraphobia (n = 1 [2%]). Thirty-eight patients (58%) had received prior treatment of their psychiatric conditions. There were no significant differences among treatment groups in terms of these characteristics, except for a significantly greater number of patients who had experienced a spontaneous panic attack in their lifetime in the phenelzine-treated group and significantly fewer patients who had previously sought treatment in the cognitive-behavioral therapy group.

Treatments

Subjects were randomly assigned to one of four treatment conditions: (1) cognitive-behavioral therapy, (2) pharmacotherapy with phenelzine and instructions for self-exposure to phobic stimuli, (3) pharmacotherapy with alprazolam and instructions for exposure, or (4) pill-placebo and instructions for exposure. Treatment assignments were made following completion of the pretest assessment. Fifteen subjects were assigned to each of the drug and placebo conditions, and 20 were assigned to the cognitive-behavioral therapy group. The difference in treatment group sizes resulted from a stratified randomization schedule (ie, one that assigned more patients to cognitive-behavioral therapy early in the subject selection process) that was designed to expedite the initiation of two 10-[illegible]t cognitive-behavioral therapy groups. Each of the treatmen[illegible]s 12 weeks in duration, and all patients were seen once weekly.

Subjects in the active medication and placebo conditions were seen individually, while subjects in the cognitive-behavioral therapy condition were treated in a group format.

At the first and fourth treatment sessions, all patients made ratings of treatment credibility and outcome expectancy using the Reactions to Treatment Questionnaire,[29] a measure that comprised a series of 10-point scales with higher numbers indicating greater credibility or more positive outcome expectancies. Analyses of variance (ANOVAs) of items from the Reactions to Treatment Questionnaire revealed that the four treatment groups did not show important statistical differences in their assessments of treatment credibility and outcome expectancy. It appeared, therefore, that the drug and cognitive-behavioral treatments were presented in a credible fashion and that patients in both the drug and cognitive-behavioral conditions held high expectancies for improvement. Thus, any resultant differences among groups on outcome measures were not likely to be due to credibility or expectancy effects.

Cognitive-Behavioral Therapy.—The cognitive-behavioral therapy condition was conducted in a group format by a team that comprised two clinical psychologists with postdoctoral training in cognitive therapy and experience in treating anxiety disorders. Two groups of 10 patients each met weekly for 2-hour sessions that were run according to a detailed social phobia treatment manual.[30] Major treatment components were cognitive-restructuring techniques, in-session–simulated social exposures, and personalized homework assignments that required both the use of cognitive-restructuring techniques and real-life exposure to previously avoided social situations. Therapists were oriented to the treatment protocol by an experienced cognitive therapist (D.B.A.), who remained available for consultation throughout the treatment program. All group sessions were audiotaped so that a manipulation check could later be performed. Two of us (C.S.G. and D.B.A.) monitored a sample of these tapes to assess adherence to the treatment manual.

Drug Treatments.—Medications were prescribed on an individual basis in a double-blind procedure by one of three psychiatrists (M.E.T., B.J.V., and T.W.U.) who met weekly with each subject for 15- to 30-minute sessions. During the weekly sessions, physicians made ratings of patients' symptoms and impairment, adjusted medication doses, and firmly encouraged patients to push themselves into phobic situations. The physician's adherence to the treatment protocol was monitored by one of us (C.S.G.) who periodically observed or audiotaped patient visits to check that patients received nonspecific, supportive contacts with a focus on encouragement to engage in exposure. Subjects took medication four times daily on a fixed dosage schedule. Dosages began at 0.7 mg/d of alprazolam and 10 mg/d of phenelzine sulfate and were increased within 4 weeks to a maximum of 6.3 mg/d of alprazolam or 90 mg/d of phenelzine sulfate. Placebos and active medications were prepared by the pharmacy at the National Institutes of Health, Bethesda, Md, in identical capsules. The pharmacy staff established and maintained the key to the medication blind. Dosages were increased until all social phobic symptoms had disappeared, until side effects precluded further increases, or until the maximum dosage was reached. The mean dose of alprazolam prescribed was 4.2 mg/d (SD, 1.3 mg/d; range, 2.1 to 6.3 mg/d), and the mean dose of phenelzine sulfate prescribed was 55 mg/d (SD, 16 mg/d; range, 30 to 90 mg/d). At the end of the 12th week, capsules were tapered and discontinued according to a planned 4-week dosage-dependent schedule, although the blinded physicians were allowed to adjust the rate of taper according to their clinical discretion (range, 2 to 5 weeks). Response to the taper schedule was variable; only one patient experienced withdrawal symptoms to an extent that warranted discharge on medication. No other patients reported symptoms of withdrawal at follow-up.

Assessment of Outcome

Scales.—Subjects were assessed at pretest (baseline), weekly during the treatment phase, at posttest (during the 12th week of treatment before discontinuation of treatment), and at follow-up (2 months following discontinuation of treatment). This report will focus on pretest, posttest, and follow-up data from self-report and physician-rated measures of social phobic and related symptoms and of overall functioning.

The self-report measures were the Social Avoidance and Distress Scale,[27] Fear of Negative Evaluation Scale,[27] Fear Questionnaire,[28] 21-item Beck Depression Inventory,[31] the State and Trait forms of the Spielberger State-Trait Anxiety Inventory,[32] the Social Interaction Self-Statement Test,[33] and the Work and Social Disability Scale.[34] The Social Avoidance and Distress Scale (range, 0 to 28) and Fear of Negative Evaluation Scale (range, 0 to 30) were developed to measure the experience of anxiety and avoidance of social situations and the fear of being evaluated negatively by others. The Fear Questionnaire (range of the Social Phobia Subscale, 0 to 40) was designed to measure change in severity of phobic avoidance and distress. The 21-item Beck Depression Inventory (range, 0 to 63) measures manifestations of depression. The State and Trait forms of the Spielberger State-Trait Anxiety Inventory, both with a range of 20 to 80, measure state and trait anxiety. The Social Interaction Self-Statement Test assesses how frequently subjects make certain facilitative and inhibiting self-statements during social interactions. It yields separate scores (range, 15 to 75) for positive and negative self-statements. The Social Interaction Self-Statement Test was administered at pretest and posttest immediately after a behavioral assessment that involved exposure to the patient's target phobic situation (eg, giving a speech, informal conversation with a stranger, writing while observed). With the exception of the Social Interaction Self-Statement Test, patients completed this self-report battery at pretest, posttest, and follow-up. The physician-rated measure was the Work and Social Disability Scale,[34] a five-point measure of symptoms and related impairment in work and social functioning (1 = no disability, 2 = mild, 3 = moderate, 4 = marked, and 5 = severe). It was rated by the treating physicians at pretest, posttest, and follow-up during routine pharmacotherapy sessions.

Analyses.—Three statistical methods were utilized to assess treatment effects as follows: (1) Outcome was assessed by analyses of covariance (ANCOVAs), with pretest scores serving as the covariate, to examine differential effects among the four treatment conditions.[35] (2) To investigate treatment response across time within groups, repeated-measures ANOVAs were performed on the physician and patient-rated scales. (3) Finally, the patients were categorized as "responders" vs "nonresponders" after treatment according to whether subjects were below or above the mean (ie, 8.8) for the general population on the Social Phobia Subscale of the Fear Questionnaire.[36,37] The Fear Questionnaire was chosen retrospectively to dichotomize the patients into responders and nonresponders because this measure has been found to be a valid and reliable measure of social phobic symptoms and accurately reflects change in response to treatment.[36]

Conservative Huynhfeldt probabilities were used for all ANOVAs, and post hoc analyses employed Bonferroni's *t* test. Bonferroni's *t* test is used for within-experiment tests. Post hoc comparisons are at the protected type I error of 5%. All probabilities less than .05 are considered to be significant, although selected probabilities less than .10 are presented in the written text or tables.

RESULTS

Of the 65 patients admitted, six (9.2%) failed to complete the treatment program. Three subjects (15%) in the cognitive-behavioral therapy group and three (6.7%) in a drug condition (two in the phenelzine-treated group and one in the alprazolam-treated group) terminated early. Of the patients in the cognitive-behavioral therapy group who dropped out, two terminated within the first 2 weeks of treatment because they did not perceive the treatment as appropriate for their problems, and one withdrew because his father was terminally ill. The patient in the

Table 1.—Repeated Measures ANOVAs on Self-report Scales*

Scale	Group†	No.	Pretest, Mean (SD)	Posttest, Mean (SD)	Follow-up, Mean (SD)	F (df)	P Level
Social Avoidance and Distress	AL	12	20.7 (7.0)	10.7 (7.9)	15.7 (5.5)	(2,106) = 49.2	<.001
	PH	13	14.9 (7.6)	6.5 (6.3)	8.3 (6.2)	(3,53) = 1.63	NS
	PP	15	18.0 (7.9)	11.0 (7.4)	13.3 (8.8)	(6,106) = 1.0	NS
	CBT	17	18.2 (9.3)	12.1 (8.7)	11.8 (8.9)	...	...
Total		57	17.9 (8.1)$_a$	10.2 (7.8)$_c$	12.2 (7.9)$_b$	...	...
Fear Questionnaire–Social Phobia	AL	12	23.6 (8.1)	12.9 (8.7)	15.8 (7.3)	(2,106) = 52.6	<.001
	PH	13	18.8 (8.7)	9.5 (8.2)	10.5 (9.9)	(3,53) = 1.7	NS
	PP	15	21.1 (3.9)	14.4 (7.1)	16.9 (7.0)	(6,106) = 0.8	NS
	CBT	17	20.8 (5.7)	11.5 (6.5)	12.5 (6.9)	...	...
Total		57	21.0 (6.7)$_a$	12.1 (7.6)$_b$	13.9 (8.0)$_b$	...	...
Work and Social Disability	AL	12	4.3 (0.5)	3.1 (1.3)	3.7 (0.9)	(2,104) = 40.8	<.001
	PH	12	4.2 (0.7)	2.8 (1.0)	2.8 (1.2)	(3,52) = 0.8	NS
	PP	15	4.3 (0.9)	3.0 (0.9)	3.3 (1.1)	(6,104) = 0.9	NS
	CBT	17	4.2 (0.8)	3.2 (0.9)	3.1 (1.0)	...	...
Total		56	4.2 (0.7)$_a$	3.0 (1.0)$_b$	3.2 (1.1)$_b$	...	...

*Fs are for time effect, group effect, and group × time interaction, respectively, for each self-report measure. There were significant time effects on all rating scales. Within each scale, means not showing the same subscript differ significantly from each other. ANOVAs indicates analyses of variance; NS, not significant.

†AL indicates pharmacotherapy with alprazolam and instructions for exposure; PH, pharmacotherapy with phenelzine and instructions for exposure; PP, pill-placebo and instructions for exposure; and CBT, cognitive-behavioral therapy.

alprazolam-treated group who dropped out was extremely sensitive to the medication and was unable to tolerate even low doses without disabling side effects. The two patients in the phenelzine-treated group who dropped out left the program within the first few days, before actually starting active treatment, because of anxiety about taking blind medications. Data from one patient who was treated with alprazolam were discarded from outcome analyses because it was revealed at follow-up that he had been noncompliant with the medication regimen. Because of missing data on some measures, not all analyses reflect the full complete sample size of 58. Differences among the treatment groups in attrition rates were examined by χ^2 tests and were not statistically significant.

No significant differences among treatment groups appeared in the analyses of pretreatment scores on the main outcome measures, indicating that random assignment to the treatment groups was effective.

Self-report Questionnaires

Repeated-measures ANOVAs showed a significant effect for time on each of the self-report scales (Table 1). Patients in all four treatment conditions showed significant within-group changes on every self-report measure from pretest to posttest and follow-up. On all but one measure, the Social Avoidance and Distress Scale, subjects maintained treatment gains at follow-up. On the Social Avoidance and Distress Scale, patients showed a significant score increment (greater avoidance) at follow-up, but they continued to report significantly less social avoidance and distress than they had at baseline. Because of space limitations, only three scales are presented in Table 1. Complete tables are available from the authors by request.

While the repeated-measures ANOVAs indicated that all four treatments decreased distress, the ANCOVAs indicated that no treatment was superior to the others. That is, the ANCOVAs (not presented) on the posttest and follow-up data failed, with one exception, to reveal significant differences among treatment groups on the self-report questionnaires. A significant difference among treatment groups was demonstrated by ANCOVA on th[illegible] Trait form of the Spielberger State-Trait Anxiety Inventory. Bo[illegible]ferroni's *t* tests revealed that at both posttest and follow-up, phenelzine-treated patients rated themselves as significantly less characteristically anxious than any of the other three groups, which did not differ significantly from each other.

From a practical perspective, it is often useful to categorize patients as responders vs nonresponders. For this purpose, we operationally identified any patient whose rating after treatment on the social phobia subscale of the Fear Questionnaire (see "Patients and Methods" section; this is a measure of phobic avoidance) was below the mean for the general population as a responder. Conversely, patients with ratings above the mean for the general population (ie, 8.8) were identified as nonresponders. This is a very rigid criterion for response and, in fact, would exclude patients who had demonstrated meaningful change.

However, we were interested in identifying those patients who we thought had demonstrated clear-cut and unequivocal improvement. Despite the inherent limitations of this strategy, it is noteworthy that 69% of the phenelzine-treated group would be categorized as responders compared with 38%, 24%, and 20% of the alprazolam-treated, cognitive-behavioral–treated, and placebo-treated patients, respectively. While two of the patients in the phenelzine-treated group had values below the population mean of 8.8 at pretreatment, there were no significant between-group differences on this measure at pretest. If these two individuals are eliminated from the data analysis, seven (63%) of the 11 patients with social phobia would still be designated as responders to phenelzine. The percentage of responders among the four groups was analyzed via a 4 × 2 χ^2 ($\chi^2 = 6.5$, $df = 3$, $P < .09$).

In summary, patients reported significantly less fear of ne[illegible]tive evaluation, social avoidance and distress, work and so[illegible] disability, state and trait anxiety, and depression at posttest and

Table 2.—Repeated Measures ANOVA on the Physician-Rated Work and Social Disability Scale*

					ANOVA Treatment × Time F = (4,64) = 4.9, $P<.002$						
					Within Group Differences, *P*			Between Group Differences, *P*			
Treatment Group	No.	Pretest (PRE), Mean ± SD	Posttest (POST), Mean ± SD	Follow-up (FU), Mean ± SD	PRE vs POST	PRE vs FU	POST vs FU	Treatment	PRE	POST	FU
Alprazolam	11	4.7 ± 0.5	1.6 ± 0.5	3.5 ± 0.7	<.05	<.05	<.05	Alprazolam vs phenelzine	NS	NS	<.05
Phenelzine	10	4.4 ± 0.5	1.9 ± 1.0	2.3 ± 0.9	<.05	<.05	NS	Phenelzine vs placebo	NS	<.05	<.05
Placebo	14	4.6 ± 0.5	3.0 ± 1.3	3.5 ± 1.2	<.05	<.05	NS	Placebo vs alprazolam	NS	<.05	NS
Total	35	4.6 ± 0.5	2.3 ± 1.2	3.1 ± 1.1	...	...	...	...	...	...	...

*ANOVA indicates analysis of variance; NS, not significant.

follow-up compared with baseline. The patients also reported a significant reduction in negative self-statements and an increase in positive self-statements at posttest. Thus, while cognitive change was the expressed goal of only one treatment condition in this study, all groups changed cognitively with no significant differences among groups.

Physicians' Ratings

The Work and Social Disability Scale (range, 0 to 5, with higher numbers indicating greater disability) was rated by physicians at all assessment points. Since they were not blind to the patients' treatment status, group therapists did not rate group members on this scale. As indicated in Table 2, repeated-measures ANOVAs yielded significant time effects. All three medication-treated groups showed significant baseline to posttreatment change. Bonferroni's *t* tests showed that all three groups were significantly improved over baseline at both posttest and follow-up. The phenelzine-treated patients maintained their gains at follow-up. The placebo-treated group showed a nonsignificant increase on this scale from posttest to follow-up but remained somewhat improved over baseline.

As shown in Table 2, there was a significant effect of treatment at posttest and follow-up. Again, only a three-group comparison among the alprazolam-, phenelzine-, and placebo-treated patients was made on this measure. Bonferroni's *t* tests demonstrated that the alprazolam- and phenelzine-treated patients were rated as significantly less impaired than the placebo-treated patients at posttest. Two months later, when the medications had been discontinued, this pattern changed. At follow-up, the phenelzine-treated group continued to be rated as significantly less impaired than the placebo-treated group. The alprazolam-treated group, while remaining somewhat improved over baseline, was not significantly different from the placebo-treated group at follow-up. These findings were unchanged when covarying for baseline scores; that is, the ANCOVAs of posttest ($F[2, 34] = 6.85$, $P<.003$) and of follow-up ratings ($F[2, 32] = 3.7$, $P<.04$) revealed a significant effect of treatment condition on work and social disability. With post hoc testing of the adjusted means, significant treatment differences ($P<.05$) were demonstrated at the identical posttest and follow-up time points presented in Table 2.

COMMENT

Well-designed comparative outcome research that examines the relative efficacy of cognitive-behavioral techniques and pharmacotherapy for social phobia has been lacking, a deficiency that this study has attempted to address. Its purpose was to examine the relative efficacy of alprazolam, phenelzine, and a cognitive-behavioral group treatment package. We compared treatment responses of 65 patients who were randomly assigned to one of four treatment conditions: alprazolam plus instructions for exposure, phenelzine plus instructions for exposure, pill-placebo plus instructions for exposure, or a group treatment package that comprised cognitive-restructuring and exposure techniques.

The results indicate that both cognitive-behavioral therapy and pharmacotherapies are effective treatments for some patients with social phobia and that, as a group, patients with social phobia seem to be responsive to treatment. Covariance analyses of self-report ratings at posttest and at follow-up failed, with only one exception, to show any significant difference among groups. The one exception was on the Trait Scale of the Spielberger State-Trait Anxiety Inventory, a self-report scale that measures the propensity to experience anxiety in stressful circumstances. On this measure, the phenelzine-treated group rated themselves as significantly less characteristically anxious at posttest and follow-up than any of the other treatment groups.

The data partially support the view that the active pharmacotherapies are superior to placebo. Analyses of the physicians' Work and Social Disability Scale ratings did not address the question of relative efficacy of the psychotherapy and pharmacotherapy because the patients who received psychotherapy were not rated on this scale. However, within the context of the drug conditions, these ratings indicated that the drugs were superior to placebo at posttest. At follow-up, the phenelzine-treated group continued to be rated as significantly less impaired than the placebo-treated group.

While our results failed to demonstrate definitively the consistent superiority of one treatment condition over the others, statistically significant repeated-measures effects were shown on all measures, indicating that the treatments were associated with substantial improvements in severe and chronic social phobia. Many patients in all conditions showed dramatic therapeutic gains on subjective ratings of social avoidance and distress, fear of negative evaluation, positive and negative self-statements and on physician and self-ratings of work and social disability. Improvements were also demonstrated on measures of anxiety and depression. Posttest and follow-up levels on these measures were comparable with those achieved in other treatment-outcome studies on social phobia that used similar interventions.[20]

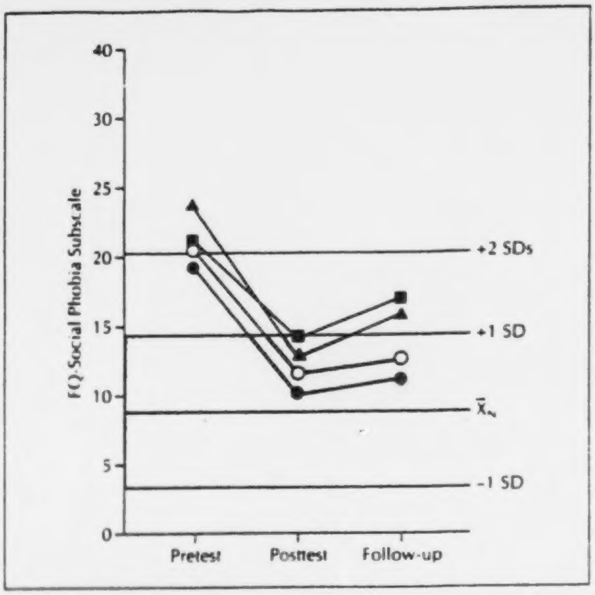

Fig 1.—*Pretest, posttest, and follow-up group means on the Fear Questionnaire (FQ)–Social Phobia Subscale compared with normative data from the adult general population. Triangles indicate the alprazolam-treated group; closed circles, phenelzine-treated group; squares, placebo-treated group; open circles, cognitive-behavioral therapy group; and $\bar{X}_N$ general population mean.*

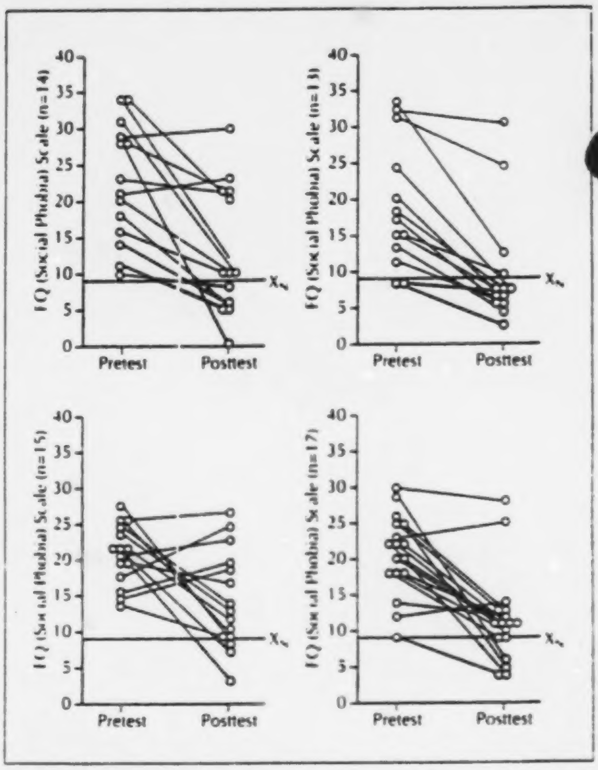

Fig 2.—*Pretest to posttest change on the Social Phobia Subscale of the Fear Questionnaire (FQ) by treatment group. Top left, Alprazolam-treated group. Top right, Phenelzine-treated group. Bottom left, Placebo-treated group. Bottom right, Cognitive-behavioral therapy group. $\bar{X}_N$ indicates general population mea[illegible]*

We looked at how our patients' posttest and follow-up ratings on the Social Phobia Subscale of the Fear Questionnaire compared with norms from a large (N = 172), randomly selected sample of adults in the general population (Fig 1).[36,37] Each of the four treatment groups had mean pretest ratings on this scale that approached or exceeded 2 SDs above the mean for the general population, indicating that ours was indeed a severely affected clinical sample. At posttest, all four treatment groups (placebo included) fell within 1 SD of the mean for the comparison group, suggesting that each of the treatment groups had, as a whole, achieved clinically significant change. However, there was a considerable amount of variability in individual responses to each of the treatments (Fig 2). Within each treatment condition, some patients made dramatic pretest to posttest changes, while in every group except the phenelzine-treated condition, there was at least one patient who rated himself as slightly more avoidant at posttest than at pretest. This trend was most apparent in the placebo-treated group.

While data supporting claims of differential efficacy among the treatments are substantially limited and controversial, we find convincing support for the conclusion that all of the treatments were associated with substantial and, in many cases, meaningful changes in severe and chronic social phobia. Patients with social phobia are, however, a heterogeneous group who respond to treatment differently, according, presumably, to different clinical and biological characteristics of their illness. In future investigations, therefore, it will be important to examine the clinical and biological characteristics of partial and complete responders and nonresponders to delineate predictors of treatment response.

Our finding that the placebo-treated group improved as much as the other specific treatment groups on self-report measures is somewhat misleading and directly related to the design of our study. That is, we strongly encouraged self-directed exposure as part of each treatment condition, including the placebo-treated group. Our study was designed in this manner to enhance external validity as all clinicians who treat social phobia will, at the minimum, encourage their patients to confront fearful situations. Accordingly, we underscore that our study lacked a true "no-treatment" control group. The specific effects of cognitive-behavioral therapy and drug treatments, therefore, are difficult to separate from the effects of self-directed exposure that was an integral part of the four treatment conditions; it was not surprising that all treatments were associated with statistically significant improvement. In fact, findings from the literature support the efficacy of exposure treatments of other anxiety disorders, with approximately 65% to 75% of patients with clinical phobias showing substantial improvements with exposure treatments.[4] Findings from previous studies also have suggested that exposure alone can be an effective treatment of social phobia.[18,23,24] Thus, the improvements in our pill-placebo and active treatment groups probably were mediated, in part, by the exposure component of the program.

An alternative explanation could be that the therapeutic gains were exclusively related to increased exposure. While the study design prohibits tests of this hypothe[illegible] our finding that clinicians rated drug-treated patien[illegible] significantly less disabled at posttest than the placebo-

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treated group argues against this explanation. A no-treatment control condition would have been useful.

The treatments differed in their abilities to promote temporally stable improvements. The alprazolam-treated group responded to treatment discontinuation with a higher relapse rate. They showed significant decreases in work and social disability while they were receiving the medication and significant increases in disability ratings with discontinuation, unlike the phenelzine-treated patients. In fact, a high percentage of phenelzine-treated patients maintained a clinically relevant response. While the placebo-treated patients were significantly improved over baseline at follow-up, a very small percentage (13%) were actually judged to be unequivocal responders (ie, they had ratings below the mean for the general population on the Fear Questionnaire). The patients in the cognitive-behavioral therapy group also demonstrated clinically relevant changes on all self-report measures at posttest compared with pretest values. However, unlike the alprazolam-treated group, there was no loss of efficacy 2 months after the patients had been discharged. In fact, there was some evidence to suggest that cognitive-behavioral therapy might be associated with even greater improvement at follow-up. This preliminary finding is provocative, and future investigations should include a long-term follow-up to clarify this.

In summary, this study has demonstrated that social phobia is amenable to a variety of treatment approaches. Two findings (that the percentage of unequivocal responders in the phenelzine-treated group [63%] exceeded the percentage of responders in any other treatment group and that patients treated with phenelzine tended to maintain therapeutic gains when medication was discontinued, while those in the alprazolam-treated group tended to relapse) suggest a trend toward greater efficacy for phenelzine in the treatment of social phobia. We caution, however, that there was not a statistically significant difference among the four groups in the percentage of unequivocal responders, nor were there any significant differences among the four groups in the main repeated-measures analyses of primary outcome measures. Also, while the phenelzine-treated group maintained treatment gains, the cognitive-behavioral therapy group showed further improvement at follow-up.

We conclude that both cognitive-behavioral therapy and pharmacotherapies (alprazolam or phenelzine) are effective treatments, when combined with exposure, for some patients who are suffering with this disorder. Both pharmacotherapy and psychotherapy can be associated with marked cognitive and behavioral changes, but no single treatment can yet be designated as most effective. Thus, depending on the training and inclination of the clinician and the preferences of the patient, it would be reasonable to use any of these modalities. The only unreasonable choice would be a decision not to treat.

This study is limited by its short-term focus. Future research can establish the time course of therapeutic gains. Future research is needed also to examine the relationship of cognitive change to reductions in avoidance and symptom relief, to identify the mechanisms by which these cognitive changes are best achieved, and to delineate predictors of response to both cognitive-behavioral and drug therapies. Combined approaches to the treatment of social phobia should also be examined. Future treatment studies should also examine the question of whether generalized and specific social phobic subtypes respond differentially to various treatments.

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PERSONALITY DISORDERS

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PERSONALITY DISORDERS - AXIS II DIAGNOSIS

LEAST RELIABLE OF ANY OF MAJOR CATEGORIES IN DSM-III-R

- NO SHARP BOUNDARIES

  NORMAL ⟷ AXIS-I DIAGNOSIS

- EXTENT TO WHICH CURRENT BEHAVIORS REPRESENT ENDURING TRAITS

PERSONALITY DISORDERS

enduring patterns of perceiving, relating to,
and thinking about ------ TRAITS

- exhibited in a wide range of important social and personal contexts
- inflexible and maladaptive
- recognized by adolescence or earlier
- continue throughout most of adult life
- certain are related to corresponding diganostic categories in childhood, adolescence
- grouped into three clusters

PERSONALITY DISORDERS

- PERVASIVENESS
- INFLEXIBILITY
- ENDURING PATTERNS
- BLIND SPOTS OR SOCIALLY UNDESIRABLE FEATURES
- MALADAPTIVITY AND IMPAIRMENT

PERSONALITY DISORDER CATEGORIES

CLUSTER A (PERSONS OFTEN APPEAR ODD OR ECCENTRIC)

PARANOID SCHIZOID SCHIZOTYPAL

CLUSTER B (PERSONS OFTEN APPEAR DRAMATIC, EMOTIONAL, OR ERRATIC)

ANTISOCIAL
HISTRIONIC
BORDERLINE
NARCISSISTIC

CLUSTER C (PERSONS OFTEN APPEAR ANXIOUS OR FEARFUL)

AVOIDANT
DEPENDENT
OBSESSIVE COMPULSIVE
PASSIVE AGGRESSIVE

PERSONALITY DISORDER NOT OTHERWISE SPECIFIED (NOS)

PERSONALITY DISORDERS FACE VALIDITY STUDY

1. 8 of three largest overlaps in meaning occurred for pairs of disorders in different clusters

2. three pairs of personality disorders had high degrees of overlap:

   avoidant --> dependent ----- 13%
   histronic --> narcissistic ----- 26%
   schizotypal --> paranoid ---- 16%

3. other patterns of overlap:

   avoidant, schizoid, schizotypal
   antisocial - sadistic
   histronic, O-C, P-A,
   with narcissistic

   narcissism may be general personality disorder concept -- that is significant component of a number of disorders

4. histronic -- only 3/8 criteria correctly assigned
   schizotypal
   avoidant -- lowest prototypical ratings

BORDERLINE PERSONALITY DISORDER

(1) Unstable / intense interpersonal relationships

(2) Impulsilveness - 2 area

(3) Affective instability

(4) Inappropriate, intense ager

(5) Recurrent suicidal threats - self-mutilating behaviors

(6) Identity disturbance

(7) Feelings of emptiness / boredom

(8) Efforts to avoid real or imagined abandonment

Three Clusters of Pathology

AFFECTIVE INSTABILITY

MAO's

TRANSIENT PSYCHOTIC PHENOMENA

HALDOL

IMPULSIVE/AGGRESSIVE BEHAVIOR

LITHIUM
PROZAC

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PSYCHOTHERAPEUTIC APPROACHES -- COMMONALITIES

(1) Relationship between the therapist and the patient

(2) Therapist's active role

(3) Need to set limits

(4) Flexibility in implementation of treatment

(5) Countertransference often evoked

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disorder. Hospital and Community Psychiatry, 42(10), 1015-1021.

Epidemiology of Borderline Personality Disorder

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The limited epidemiological data available on borderline personality disorder suggest that the prevalence of the disorder is between .2 and 1.8 percent in the general community, 15 percent among psychiatric inpatients, and 50 percent among psychiatric inpatients with a diagnosis of personality disorder. No data on the incidence—the rate of new cases—of the disorder have been reported, and inferences about incidence based on prevalence rates are complicated by differences in the formal designation of personality disorders before and after DSM-III was issued. Current findings suggest that about 76 percent of borderline patients are female. Epidemiological study of borderline personality disorder has been hindered by the lack of a brief semistructured interview that can be used with large population samples and that does not require substantial clinical expertise. The authors discuss alternative research methods, including use of lay interviewers, recoding of existing data, telephone interviews, and self-report inventories.

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Epidemiology is the study of the distribution and determinants of disorders (1,2). Epidemiologic studies yield data on prevalence rate (the number of cases of a given condition at a particular time) and incidence rate (the number of new cases in a population), as well as on correlates (conditions and variables associated with occurrence of the disorder) and factors associated with risk of developing a disorder.

Borderline personality disorder has been of considerable clinical and theoretical interest, and a review of its epidemiology is certainly warranted. However, epidemiologic research requires systematic, reliable sampling of large numbers of representative cases within explicitly defined community and clinical populations (3); it is therefore very expensive. Epidemiologic research in psychiatry has benefited substantially from the development of specific, explicit diagnostic criteria and structured interviews that can be administered by lay interviewers (4). Epidemiological research on the personality disorders, however, has been hindered by difficulty in defining a disorder of personality using a brief list of specific symptoms and difficulty in assessing such a disorder by a concise set of simple and direct questions that require little or no inference or judgment on the part of the rater (5–7).

Antisocial personality disorder was the only personality disorder to be included in the Epidemiologic Catchment Area (ECA) study sponsored by the National Institute of Mental Health (8). The *DSM-III-R* diagnosis of antisocial personality disorder has the most specific and explicit diagnostic criteria of the personality disorders, but the validity of these criteria has been controversial precisely because of their specificity (9,10). Use of a brief list of specific questions to assess an equally concise set of criteria to diagnose borderline personality disorder would be even more difficult and controversial (11). The most popular semistructured interview for assessing borderline personality disorder is the Diagnostic Interview for Borderlines–Revised (DIB-R), which takes about an hour to administer and requires "substantial clinical experience" (12, p. 12).

Because of these limitations, there are few data on the epidemiology of borderline personality disorder in large community samples. In this paper, we review existing studies and provide estimates of epidemiologic parameters based on data reported in these studies. Our discussion is necessarily confined to questions of prevalence, incidence, and sex ratio, for which there still remains substantial controversy and dispute. We conclude our review with a discussion of alternative approaches to obtaining epidemiologic data on borderline personality disorder.

Prevalence

Based on epidemiologic studies conducted before *DSM-III* was issued, Merikangas and Weissman (13) estimated the prevalence of borderline personality disorder within the community to be between .2 percent (14) and 1.7 percent (15). The latter figure is remarkably close to more recent estimates. Swartz and associates (16) recoded data collected in Durham, North Carolina, using the Diagnostic Interview Schedule

(DIS) as part of the ECA study (8). The prevalence rate of borderline personality disorder among the 1,541 community residents in the sample, who were between ages 19 and 55, was 1.8 percent.

Zimmerman and Coryell (17) interviewed 797 relatives of normal control subjects and of schizophrenic and depressed patients using the Structured Interview for DSM-III Personality Disorders (SIDP) (18). They reported a prevalence rate of 1.6 percent for borderline personality disorder. One of the more curious findings was that borderline personality disorder was not the most prevalent personality disorder diagnosed in the sample. Six personality disorders were diagnosed more frequently than borderline personality disorder. A total of 3.3 percent of the subjects received a diagnosis of passive-aggressive personality disorder.

Zimmerman and Coryell (19) also administered the Personality Diagnostic Questionnaire (PDQ) (20), a self-report instrument, to 697 relatives of psychiatric patients and normal control subjects. The prevalence rate of borderline personality disorder based on the PDQ was 4.6 percent. Reich and colleagues (21) sent the PDQ to 379 adults randomly selected from a university community in Iowa with a population of more than 36,000. The prevalence rate of borderline personality disorder in the 235 respondents was 1.3 percent.

Widiger and Trull (22) identified 30 studies published between 1975 and 1988 that used a clinical interview and provided sufficient data to estimate prevalence of borderline personality disorder in specific populations of psychiatric patients. The average prevalence across eight outpatient studies that had no inclusion or exclusion sampling criteria was 8 percent; for the 14 inpatient studies with no exclusion or inclusion criteria the average prevalence was 15 percent. In four outpatient studies that were confined to patients with a personality disorder, the prevalence of borderline personality disorder was 27 percent, and in four inpatient studies that were confined to patients with a personality disorder, the prevalence rate was 51 percent.

Widiger and Trull (22) also summarized the results from 14 studies that examined the prevalence rate for all 11 personality disorders. Borderline personality disorder was typically the most prevalent, and the differences between the rate of that disorder and the rates of other personality disorders were substantial in some studies. In a study by Zanarini and colleagues (23) of inpatients admitted with a probable axis II diagnosis, borderline personality disorder was diagnosed in 60 percent of the cases. The next most frequently diagnosed personality disorder was histrionic personality disorder, with a prevalence rate of 42 percent (subjects in this study and in those discussed below could receive more than one diagnosis).

Standage and Ladha (24) reported that 70 percent of the cases in a sample drawn from a general hospital psychiatric inpatient unit were diagnosed with borderline personality disorder; the next highest prevalence was 55 percent for dependent personality disorder. In a study by Skodol and colleagues (25) of applicants for admission to a long-term treatment program for severe personality disorders, 62 percent of the subjects received a diagnosis of borderline personality disorder; 49 percent received a diagnosis of avoidant personality disorder.

Among a sample of outpatients studied by Morey (26), most of whom had a diagnosis of personality disorder, 32 percent had a diagnosis of borderline personality disorder and 22 percent had a diagnosis of histrionic personality disorder. Hyler and Lyons (27) found a 21 percent prevalence rate of borderline personality disorder in a sample composed mostly of outpatients referred by psychiatrists who treated a large number of patients with personality disorder; the next highest prevalence rate in the sample was 11 percent for obsessive-compulsive personality disorder.

The prevalence rates for most personality disorder diagnoses tend to be much lower in data sets drawn from hospital and clinic charts than would be suggested by results of studies using semistructured interviews (28,29), but the diagnosis of borderline personality disorder may provide one exception to this trend. Koenigsberg and others (30) obtained the medical chart diagnoses for 2,462 patients. Borderline personality disorder was diagnosed in 12 percent of the cases. The next most frequent personality disorder diagnosis was histrionic personality disorder, diagnosed in only 3 percent of the cases.

Loranger (31) studied the prevalence of personality disorder diagnoses in a sample of patients treated in a university-affiliated psychiatric hospital between 1981 and 1985, the first five years after *DSM-III* was issued. Of a total of 5,771 patients, 2,840 received a diagnosis of personality disorder. The most common diagnosis was atypical, mixed, or other personality disorder, diagnosed in 32.6 percent of 2,916 cases among the 5,771 patients. Borderline personality disorder was diagnosed in 26.7 percent of the cases, and the distant third was dependent personality disorder, diagnosed in 9.1 percent of the cases.

Incidence

The high prevalence rates that have been obtained for borderline personality disorder call into question the validity of the diagnosis. Borderline personality disorder was not formally recognized as a diagnosis until 1980, but the disorder is now diagnosed more frequently than any other personality disorder. About 15 percent of all inpatients and half of all inpatients with a personality disorder receive this diagnosis (32).

Examination of the incidence of borderline personality disorder—the rate of new cases in the population at risk during a specified period of time (3)—could help clarify findings about the prevalence of the disorder. However, no data on the incidence of borderline personality disorder has been reported.

Loranger's study (31) of the prevalence of the disorder did include a comparison of clinical diagnoses made before and after *DSM-III* was issued. In that study, the most prevalent personality disorder diagnoses made between 1975 and 1979, before *DSM-III* became available, were "other" (54.3 percent of 984 cases diagnosed with a personality disorder), hysterical personality (9.5 percent), antisocial personality (9.3 percent), schizoid personality (5.8 percent), and passive-aggressive personality (5.5 percent). From 1981 to 1985, after *DSM-III* was issued, the most prevalent diagnoses were atypical, mixed, or other (32.6 percent of 2,916 cases of personality disorder), borderline personality disorder (26.7 percent), dependent personality disorder (9.1 percent), narcissistic personality disorder (5.9 percent), and antisocial personality disorder (4.6 percent).

One could not, however, infer an increased incidence of borderline personality disorder from Loranger's data. These data show that the prevalence rate for any personality disorder diagnosis increased dramatically, from 19.1 percent of all cases before *DSM-III* to 49.2 percent of all cases after *DSM-III*. The increase appears to reflect the conversion to a multiaxial diagnostic system rather than an actual increased incidence of personality disorders. In the development of *DSM-III*, the principal reason personality disorders were placed on a separate axis was to encourage clinicians to overcome the tendency to miss or ignore the presence of a personality disorder in the context of a more florid or immediate clinical syndrome (33). Loranger's data suggest that this educational aim has been accomplished.

Millon (34) suggested that the current prevalence of borderline personality disorder does in fact reflect increased incidence. Millon wrote, "Our contemporary epidemic of borderline personality disorder can be best attributed to two broad sociocultural trends that have come to characterize much of Western life this past quarter century, namely the emergence of social customs that exacerbate rather than remedy early, errant parent-child relationships and, second, the diminished power of formerly reparative institutions" (34, p. 355). Examples of divisive social customs include rapid industrialization, changing sex roles and increased divorce, poor role models in the media, and increased availability of illegal drugs. Examples of diminished reparative institutions include declining schools and religious institutions and the absence of nurturing surrogates due to the scattering of the nuclear and extended family.

It could also be the case that 15 percent of all inpatients had borderline personality disorder before *DSM-III* but that they received instead the nonspecific diagnosis of "other" or a diagnosis of hysterical or passive-aggressive personality. Vaillant (35), however, has argued that the current prevalence rates may be somewhat iatrogenic. He wrote, "These disorders are still usually observed only in American cities that have opera houses and psychoanalytic institutes" (35, p. 543). There may be some truth in Vaillant's suggestion that the prevalence of borderline personality disorder reflects local interest. The high rates of borderline personality disorder reported by Koenigsberg and others (30) and Loranger (31) were found in studies conducted at Cornell University Medical College, where considerable attention has been given to the borderline diagnosis.

The excessive prevalence, however, is consistent with Kernberg's formulation (36) of borderline personality disorder as a borderline level of personality organization. Borderline personality organization does not refer to a distinct personality disorder but rather a level or degree of personality dysfunction. Borderline personality organization may be compared with other types of personality organization rather than with various types of personality disorders such as histrionic, antisocial, or schizotypal personality disorder. Borderline personality organization is distinguished from neurotic personality organization by a predominance of primitive defensive operations centering on the mechanism of splitting; it is distinguished from psychotic personality organization by its maintenance of a capacity for reality testing. Many if not most inpatients with a personality disorder would likely be functioning at a borderline level of personality organization.

The excessive prevalence of borderline personality disorder is also consistent with an interpretation of the disorder as representing excessive neuroticism (37). A general trait of personality dysfunction, excessive neuroticism includes elements of impulsivity, hostility, anxiety, depression, self-consciousness, and vulnerability and would likely be characteristic of a substantial proportion of mentally ill patients.

Sex ratio

DSM-III-R states that borderline personality disorder is more commonly diagnosed in females than in males (38). Akhtar and others (39) verified this clinical impression in a meta-analysis of 23 studies. Across the 23 studies, the average percentage of cases of borderline personality disorder in which the patient was female was 77 percent. However, they included results from studies with overlapping data sets and biased samples. For example, they included the results of a study by Loranger and others (40) although the sample in that study was intentionally and explicitly limited to females. Widiger and Trull (22), however, identified 75 studies that provided nonoverlapping and unbiased estimates of the sex ratio for borderline personality disorder. In those studies the average percentage of cases involving female patients was 76 percent, with a 95 percent confidence interval of 73 to 80 percent, a finding consistent with that of Akhtar and associates.

Other researchers have argued, however, that the increased rate of borderline personality disorder in females reflects sex bias by diagnosing clinicians (41). Henry and Cohen (42) administered a 35-item questionnaire based on the features of borderline personality disorder to 277 college students (80 males and 197 females). Males scored significantly higher on items concerned with impulsivity, unstable relationships, identity disturbance, and feelings of emptiness.

Henry and Cohen indicated that because normal males acknowledge more borderline personality disorder symptoms than normal females, it was inconsistent that females would be more likely than males to receive the diagnosis. They suggested that clinicians might consider borderline personality disorder traits to be congruent with the masculine sex role and thus find them more acceptable in males, whereas "in women these traits may be seen as less appropriate to [their] sex role, and therefore women may be more likely to be labeled as having borderline personality disorder" (42, p. 1529).

Henry and Cohen's hypothesis suggests that a self-report assessment of borderline personality disorder would provide a different sex ratio than diagnoses based on clinical interviews. However, this has not been the case. Females have typically scored higher than males on the Personality Diagnostic Questionnaire and on the scales for borderline personality disorder in the Minnesota Multiphasic Personality Inventory (MMPI) (43).

Kass and associates (44) and Reich (43) reported that the proportion of women who received a diagnosis of borderline personality disorder was not significantly higher than the proportion of women seen at the respective clinics where the data were collected. Both authors suggested that these findings are inconsistent with the sex bias hypothesis, since clinicians did not tend to give the diagnosis to more women than would be expected, given the number of women who sought treatment. However, there is no reason to presume that the proportion of women with borderline personality disorder should be equivalent to the proportion of women treated in a given setting. Simply because there are more females than males at a clinic does not suggest that there will be more females than males with every disorder (including borderline personality disorder) that is diagnosed at that clinic (45).

In their comparison of clinicians' diagnoses based on clinical impression versus clinicians' diagnoses based on a systematic assessment of each *DSM-III* criterion for borderline personality disorder, Morey and Ochoa (46) found that clinicians tended to give a diagnosis of borderline personality disorder to patients who met the criteria of suicidal gestures, self-damaging impulsivity, and affective instability or any combination of these criteria, even though the patient lacked additional features of borderline personality disorder. Less experienced clinicians, psychodynamically oriented clinicians, and female clinicians were also more likely to give a diagnosis of borderline personality disorder, and white patients with a low income were more likely to receive this diagnosis. Females were only marginally more likely to be given a diagnosis of borderline personality disorder, and the effect of gender was insignificant compared with the other effects noted.

Widiger and Trull (22) compared the sex ratios obtained in studies of borderline personality disorder that used a semistructured interview (N=34) to those obtained in studies that used an unstructured clinical interview (N=41). If sex biases affect clinicians' diagnoses, one would expect the proportion of women with the diagnosis to be higher in studies that did not use a structured interview. However, the opposite result was found. The average proportion of women with the diagnosis of borderline personality disorder was 80 percent in studies that used a semistructured interview and 73 percent in studies that used an unstructured interview ($z=3.05$, $p<.01$).

Methodological innovations

A reasonable epidemiologic study of borderline personality disorder might require the administration of a semistructured interview by experienced clinicians to more than a thousand subjects chosen by a probability sampling. The cost of such a community study would be substantial and perhaps prohibitive. One may then ask whether an epidemiologic study of borderline personality disorder at this time would be worth the cost.

A large-scale epidemiologic study would likely provide useful estimates of prevalence, risk factors, and correlates, but these data would still be ambiguous because the validity of the diagnosis is still in question. It would be especially important to assess whether findings about the epidemiology of borderline personality disorder could be adequately explained using more traditional concepts of personality disorder, such as dependent and histrionic personality disorder, or by more traditional concepts of personality, such as neuroticism. The inclusion of additional measures of personality and personality disorder would be very important to the internal validity of the study design but would escalate the cost considerably.

However, a variety of alternative approaches to assessment that might reduce the cost have been proposed. These strategies include the use of lay interviewers, use of data that have been recoded from earlier studies, telephone interviews, and self-report inventories. Each of these options will be discussed in turn.

Lay interviewers. The success of the ECA study was due in part to the development of a structured interview that could be administered by persons with little or no professional or clinical experience (4). Antisocial personality disorder could be included in the Diagnostic Interview Schedule form used in the ECA study because the criteria for this diagnosis, such as unemployment and illegal activity, require relatively little clinical inference and judgment. It is questionable whether a lay interviewer could assess the more subtle criteria for borderline personality disorder, such as identity disturbance or chronic feelings of emptiness and boredom (7).

However, lay interviewers could be trained to assess the criteria for borderline personality disorder; in fact, some studies of the disorder have successfully used them (47). One advantage is that lay interviewers lack the clinical assumptions and expectations that tend to bias findings (7). On the other hand, training and supervising them can be expensive. Widiger and associates (47) found that these activities required more time and effort than would have been required if experienced clinicians had been employed. However, only 84 subjects were interviewed in their study. The benefits of using lay interviewers may outweigh the cost when sample sizes exceed 500.

Recoding existing data sets. Swartz and associates (16) derived epidemiologic data on personality disorder by recoding data collected using the DIS in the ECA study. However, the DIS obtained axis I symptoms that had occurred during the past year such as suicide attempts, anxiety attacks, anxiety for one month or more, tenseness or jumpiness, and three or more depressive symptoms. These symptoms are likely to be seen in borderline patients during a one-year period, but inferring the presence of borderline personality disorder on the basis of axis I symptoms that are known to have occurred only during the last year risks confusing a personality disorder with a mood disorder.

It is not surprising that Swartz and associates found substantial comorbidity of borderline personality disorder with mood and anxiety disorders, given that the respective diagnoses were based on the same diagnostic criteria. In a separate report by Swartz and associates (48), diagnoses of borderline personality disorder using DIS data showed significant agreement with diagnoses using the DIB, but these findings could also raise questions about the validity of the DIB borderline personality disorder diagnosis. To the extent that borderline personality disorder can be diagnosed on the basis of axis I symptoms that have occurred during the past year, borderline personality disorder may be no more than another name for a nonspecific assortment of axis I symptomatology.

The recoding of existing data sets saves the expense of collecting new data, but one does need to ensure that the algorithm provides a valid facsimile of the diagnostic criteria for borderline personality disorder. It is particularly important to ensure that the symptoms are lifelong and chronic, given the ease with which axis I disorders are confused with axis II disorders (28,49).

Telephone interviews. Telephone interviews can provide a substantial savings in time and effort. The epidemiologic interviews of 797 subjects by Zimmerman and Coryell (17) were conducted for the most part by telephone. Only about 27 percent of those interviews were conducted in person.

Kendler (50) questioned the validity of these telephone assessments, which used the Structured Interview for DSM-III Personality Disorders. He noted, for example, that the SIDP requires observation of nonverbal responses to assess the schizotypal personality disorder criterion of inadequate rapport in face-to-face interactions (19).

There is also a risk that a telephone interview will provide an overly simplistic assessment. Zimmerman and Coryell (17) did not indicate the average length of each interview, nor did they provide any control for confidentiality (that is, the subjects may not have been alone during the interview). They indicated that there were no significant differences between the prevalence rates obtained using face-to-face interviews and those obtained using telephone interviews, but the actual data were not provided. Zimmerman and Coryell subsequently provided the correlation of the PDQ and SIDP scores for 697 of the subjects (19). Agreement about the presence of a diagnosis of borderline personality disorder was not substantial, but it was statistically significant ($k=.30$, $p<.05$); agreement in subjects' total scores on items assessing borderline personality disorder was also small, but again it was significant ($r=.39$, $p<.01$). Agreement was no better for the face-to-face interviews than for the telephone interviews.

Skepticism about the validity of telephone interviews for personality disorders is understandable, but most of the limitations would also apply to a self-report inventory. The criteria for borderline personality disorder may be assessed without face-to-face contact, and a telephone interview at least provides the opportunity for follow-up questions and probes that is not available in studies using a self-report inventory.

Self-report inventories. Self-report inventories have been the customary method used in psychological research on adaptive and maladaptive personality traits. One advantage is the ability to obtain the responses to a large number of structured questions from a large number of subjects in a systematic, objective, and reliable manner. The potential application of this methodology to epidemiologic research on personality disorders is evident. The recent revision of the Minnesota Multiphasic Personality Inventory involved to a large extent an epidemiologic study with self-report inventories (51).

The customary method for researching personality disorders has been with semistructured interviews. The major limitation of self-report inventories is the inability to conduct open-ended probes and to add or alter questions in response to statements by or observations of the subject. However, as one increases the structure of an interview to minimize professional inference and judgment to the point that a lay person can conduct the interview with direct questions that have structured responses, there may be little lost by simply providing a self-report questionnaire.

An additional concern about self-report inventories, however, is that responses may be affected substantially by the depressed, manic, or anxious state of the subject (49). In the epidemiologic study by Zimmerman and Coryell (19), there was a significant tendency for responses to the PDQ questionnaire to result in more diagnoses of personality disorder than responses to the SIDP interview. For example, a total of 4.6 percent of the subjects who answered the PDQ met criteria for borderline personality disorder, compared with 1.7 percent of subjects who responded to the SIDP. However, use of the SIDP resulted in more persons being diagnosed with a personality disorder than did use of the PDQ (13.5 percent, compared with 10.3 percent). In other words, the interviewers diagnosed more persons with a personality disorder but gave substantially fewer diagnoses for each individual.

The discrepancy between the SIDP and the P Q was associated primarily with transient depression and the lie scale of the PDQ, which included items such as "I am the worst person in the world." This as-

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sociation suggests that subjects' self-reports of their maladaptive personality traits were exaggerated. It is possible, however, that a different self-report inventory could provide more reliable results.

Conclusions

Clinical research has suggested that borderline personality disorder is a prevalent personality disorder, particularly within inpatient samples. The frequency with which borderline personality disorder is diagnosed, however, may be inconsistent with the construct of the disorder as a distinct clinical condition. Rather, the excessive prevalence may be more consistent with an interpretation of borderline personality disorder as indicating a degree of personality dysfunction or disorganization.

Researchers are far from providing conclusive data about the epidemiology of borderline personality disorder within community samples, although substantial research on the disorder within clinical settings exists. A meta-analysis of the research to date suggests that about 76 percent of borderline patients are female, but even this basic finding is not without dispute.

The cost of conducting an extensive epidemiologic study of borderline personality disorder may be prohibitive, and this expense may not be warranted given the ambiguity of results obtained using currently available assessment instruments. In the meantime, alternative methodologies are worth pursuing, particularly the use of telephone interviews, lay interviewers, and self-report inventories.

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Assessment and Diagnosis of Borderline Personality Disorder

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Borderline personality disorder is common in treatment settings and may be so in the general population. In this guide to assessment strategies for diagnosing borderline personality disorder, the authors discuss the reliability and validity of structured interviews and self-report instruments and suggest the use of a self-report questionnaire as a cost-effective screening test. Assessment problems, such as the need for longitudinal observation, are reviewed. Essential features of the recommended diagnostic approach include clarity about the diagnostic concept, consideration of the full range of diagnostic criteria, incorporation of recently developed diagnostic methodologies, care in distinguishing personality disorders from comorbid axis I syndromes, and complete assessment of the full range of axis II disorders.

Borderline personality disorder is certainly common in treatment settings and may be so in the general population. In a 1989 review of systematic studies, Widiger and Frances (1) estimated that 11 percent of all psychiatric outpatients and 19 percent of all inpatients have the diagnosis. Borderline personality disorder may account for one-third of all outpatient diagnoses of personality disorder and almost two-thirds of all such inpatient diagnoses. In the community, where less systematic research has been conducted, estimates vary widely from a low of .2 percent to a high of 15 percent.

Not only is borderline personality disorder common, but it also presents a considerable clinical challenge. The disorder can be difficult to diagnosis and to treat and can predispose to, be accompanied by, or interfere with the treatment of many other mental disorders. The purpose of this paper is to offer a guide to assessment strategies for diagnosing borderline personality disorder.

Concepts and criteria

The prevalence of borderline personality disorder varies not only by the setting in which an assessment is made but also by the definition of the disorder used. The borderline concept dates back 50 years. Over the years, however, the term borderline has had multiple meanings and has referred to diverse patient groups (2). Modern attempts to characterize borderline patients have emphasized definition by diagnostic criteria, culminating in the diagnostic criteria for borderline personality disorder

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developed by Spitzer and colleagues (3) and adopted for *DSM-III* (4).

Current concepts. The three most commonly described concepts of borderline personality today are those of Gunderson and associates (5,6), those of Kernberg (7,8), and those described in *DSM-III* and *DSM-III-R* (4,9). Based on the work of Spitzer and colleagues (3), *DSM-III* divided patients often referred to as borderline into two groups, one characterized by instability of mood, interpersonal relationships, self-image, and impulse control and the other characterized by deficits in interpersonal relatedness and peculiarities of ideation, appearance, and behavior. The disorder of the former group was given the name borderline personality disorder, which was believed to be comparable to the concept of borderline that grew out of the psychoanalytic literature. The disorder of the latter group was designated schizotypal personality disorder, which was thought to describe persons with so-called borderline schizophrenia in the Danish adoption studies of schizophrenia (10,11). In this paper, we focus primarily on a descriptive model for the diagnosis of borderline personality disorder, as represented by *DSM-III* and *DSM-III-R* criteria rather than on a model based on developmental history or unconscious motivation.

Conceptually, the criteria of Gunderson and associates, Kernberg, and *DSM-III* for borderline personality disorder are similar but not identical. Gunderson's diagnosis includes characteristic dysphoric affects, such as anger, depression, anxiety, and emptiness; unstable interpersonal relationships; and poor impulse control leading to self-damaging acts. All of these criteria are included in *DSM-III*, but Gunderson also emphasizes brief psychotic experiences, dissociative states, or other cognitive distortions, which are not part of the *DSM-III* concept. *DSM-III*, on the other hand, includes a criterion of identity disturbance, which is not emphasized by Gunderson. Kernberg's concept of borderline personality organization emphasizes an unstable sense of self, use of primitive defense mechanisms, and temporary lapses in—but overall maintenance of—reality testing. Kernberg's concept is hypothesized to cut across a number of severe personality disorder subtypes as described in *DSM-III*, for example, narcissistic, antisocial, and schizoid personality disorders (12).

Morey (13) has shown that *DSM-III-R* criteria for borderline personality disorder identify virtually the same patients as *DSM-III* criteria (k = .97). The relationship between borderline personality disorder as diagnosed by *DSM-III* and the disorder as diagnosed by other criteria has been studied but is less clear. Of six studies that have applied *DSM-III* criteria and Gunderson's criteria to the same patients, two found the Gunderson concept to apply to more persons (14,15), one found that *DSM-III* fit more persons (16), and three found no difference (17–19).

Our group used a self-report instrument and a semistructured interview to assess borderline personality organization and its three subcomponents in a sample of patients with personality disorders (20,21). We found that, as predicted, patients with personality disorders theoretically at the borderline level of functioning tended to be intermediate between patients with diagnoses at the neurotic and psychotic levels (8).

Kernberg and associates (22) and Koenigsberg (23) reported modest agreement (k = .45 and .49, respectively) between structural diagnoses of borderline personality organization and Gunderson's borderline diagnosis made by structured interview. Kullgren and Armelius (24) found that borderline personality organization described patients with a wide variety of *DSM-III* axis I and II disorders; 46 percent of patients with borderline personality organization had borderline personality disorder, but 20 percent of patients with borderline personality disorder did not have borderline personality organization.

Cases fitting multiple definitions of borderline personality disorder may be considered likely to represent true cases, but when discrepancies exist, mere disagreement is not informative. It is necessary to determine whether disagreements occur in cases near the diagnostic thresholds of the various systems and whether one definition is more useful than another for clinical or research purposes.

Criteria and diagnostic categories. *DSM-III* and *DSM-III-R* both define borderline personality disorder with a polythetic criteria set; any five of eight criteria are sufficient for the diagnosis. A polythetic format implies that all criteria are of equal diagnostic significance. Is this assumption warranted?

Individual traits or behaviors might be considered diagnostically relevant because they are very typical of a disorder or because they are very useful in differentiating one disorder from another. The most characteristic features need not be the most discriminating. The proportion of patients with the disorder who have a characteristic symptom is called the sensitivity of the symptom. A symptom's positive and negative predictive power, that is, its value in identifying or ruling out a disorder, are measures of its discriminative value.

In a review of 14 research studies, Widiger and Frances (1) found that impulsivity and affective instability were the most characteristic manifestations of borderline personality disorder but that physically self-damaging acts, unstable-intense interpersonal relationships, and impulsivity were the most diagnostically useful. Surveys of clinicians found that identity disturbance, intense and inappropriate anger, unstable relationships, and impulsivity were believed to be most typical (25,26). The majority of studies found the *DSM-III* criterion of intolerance of being alone to be poorly associated with a diagnosis of borderline personality disorder and to be rated as least typical by clinicians. This was the one criterion changed (to abandonment fears) in *DSM-III-R*.

Widiger and Frances (1) point out that the diagnostic importance of a symptom may vary depending on the setting in which a patient is seen and the differential diagnosis that is at issue. In outpatient settings, the relatively uncommon behaviors subsumed under physically self-damaging acts have the highest positive predictive value for borderline personality disorder. Unstable-intense relationships are more rare and are more specific for borderline personality disorder among inpatients than among outpatients. Outpatients' relationships are apparently more commonly unstable regardless of their personality disorder diagnoses.

These analyses leave unanswered the question of whether there is a core set of symptoms for borderline personality disorder (27) and other symptoms that are a function of comorbid disorders, psychobiology, or severity, chronicity, or other nonspecific aspects of a patient's psychopathology. Some symptoms, such as affective instability, are inevitably present in patients with comorbid mood disorders (see below) and may not turn out to be central features of the borderline construct at all. Furthermore, the requirement that five of eight criteria define borderline personality disorder is admittedly arbitrary (28,29). Should a patient who meets the three or four most characteristic and distinctive criteria not receive the diagnosis?

Until a system can be devised to weight particular criteria differentially and result in accurate diagnoses in a variety of settings and patient populations, the eight *DSM-III-R* criteria must be considered as defining a prototype. The more features a patient exhibits, the more certain the diagnosis. Subthreshold cases with highly typical or specific symptomatology may be viewed as provisional cases pending further evaluation. Subthreshold cases with mostly nonspecific symptoms, such as affective instability, anger, and fears of abandonment, strongly suggest that another disorder may be present.

Morey and Ochoa (30) have studied how closely practicing psychiatrists and psychologists adhere to *DSM-III* criteria in assigning diagnoses of personality disorders. Although clinicians diagnosed borderline personality disorder fairly consistently in accord with diagnostic criteria, some misdiagnosis relative to other personality disorders occurred. Less experienced clinicians tended to diagnose borderline personality disorder when a patient did not meet the full criteria, and more experienced clinicians tended not to make the diagnosis even when patients actually met criteria. Poorer patients were more likely to receive a diagnosis without meeting criteria, while wealthier patients went undiagnosed despite sufficient symptomatology. There were weaker tendencies for psychodynamically oriented clinicians to overdiagnose and for psychologists to underdiagnose.

Borderline personality disorder is more commonly diagnosed in women than in men (31). Labeling processes have been implicated as contributing to the overrepresentation of women (32). Morey and Ochoa (30) found a relationship, though relatively weak, between a patient's gender and misdiagnosis: female patients tended to receive the diagnosis undeservedly. Interestingly, female clinicians tended to overdiagnose the disorder, and male clinicians tended to underdiagnose it.

However, in Morey and Ochoa's study (30), symptom patterns reflecting idiosyncratic diagnostic practice were more strongly associated with misdiagnosis than were demographic or practitioner variables. Among the symptoms of borderline personality disorder, suicidal threats and gestures were associated with overdiagnosis when present and with underdiagnosis when absent. Other evidence of impulsivity and affective instability were also associated with overdiagnosis. These results suggest that clinicians tend wrongly to equate mood disturbance and impulsive suicide attempts with borderline personality disorder. We return to the problem below.

Diagnostic methods

The burgeoning interest in borderline personality disorder as a research focus (33,34) has spawned a plethora of tools to assist in the diagnostic process. There are currently five structured or semistructured interviews available to diagnose borderline personality disorder as well as the other personality disorders included in *DSM-III-R*, three others focused solely on borderline concepts, five self-report questionnaires covering all of axis II, and one more self-report instrument specifically designed to assess borderline pathology. Table 1 lists these instruments and interviews along with some of their features.

A major difference between the interviews for axis II disorders is the format by which the questions are organized. The Structured Interview for DSM-III-R Personality Disorders (35), the Personality Disorder Examination (PDE) (36), and the revised version of Personality Interview Questions (PIQ-II) (37) are organized on the basis of six to 17 areas of functioning, such as work, affects, or interpersonal relations. Questions in the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II) (38) and the Diagnostic Interview for Personality Disorders (DIPD) (39) are organized by the personality disorder that they are meant to explore.

All of the interviews are explicitly designed to be administered by experienced clinical personnel, except for the PIQ-II, which has been used in studies by trained lay interviewers. The Diagnostic Interview for Borderlines (DIB) (40) has recently been revised by Zanarini and colleagues (41) to improve its ability to distinguish patients with borderline personality disorder from patients with other axis II disorders. The DIB-R questions are grouped into sections on affect, cognition, impulse action patterns, and interpersonal relationships. The DIB-R differs from the DIB in that the nondiscriminating section on social adaptation has been deleted, impulse action patterns and characteristic disturbances in interpersonal relations have been given more diagnostic weight relative to the affect and cognition (formerly psychosis) sections, and the interview now focuses on the past two years of the patient's life. Some specific items have also been changed.

The characteristics of these instruments have been previously reviewed in detail (42–44). Here we mention briefly their ability to improve reliability of the diagnosis of borderline personality disorder and their validity.

Reliability. The reliability of

Table 1
Features of interviews and self-report instruments for the assessment of borderline personality disorder

Interview or instrument	Author	Type	Diagnostic range	Special features
Structured Interview for DSM-III-R Personality Disorders	Pfohl et al. (35)	Interview	All axis II disorders	Patient and informant questions
Personality Disorder Examination	Loranger (36)	Interview	All axis II disorders	Detailed instruction manual
Structured Clinical Interview for DSM-III-R Personality Disorders	Spitzer et al. (38)	Interview	All axis II disorders	Axis I section; axis II screening questionnaire
Diagnostic Interview for Personality Disorders	Zanarini et al. (39)	Interview	All axis II disorders	Best test-retest reliability
Personality Interview Questions–II	Widiger (37)	Interview	All axis II disorders	Nine-point scale for traits and behaviors
Diagnostic Interview for Borderlines	Gunderson et al. (40)	Interview	Borderline personality disorder	Gunderson criteria
Borderline Personality Scale	Perry & Cooper (85)	Interview	Borderline personality disorder	Highly structured
Schedule for Interviewing Borderlines	Baron & Gruen (86)	Interview	Borderline personality disorder	Companion schizotypal section
Personality Diagnostic Questionnaire–Revised	Hyler et al. (48)	Self-report	All axis II disorders	Face valid items
Millon Clinical Multiaxial Inventory–II	Millon (51)	Self-report	All axis II disorders	Dimensions of axis I and axis II psychopathology
Wisconsin Personality Inventory (Revised)	Klein (87)	Self-report	All axis II disorders	Integrates structural analysis of social behavior model[1]
Schedule for Normal and Abnormal Personality	Clark (89)	Self-report	All axis II disorders	Normal and abnormal personality measures
Minnesota Multiphasic Personality Inventory (MMPI) scales for DSM-III personality disorders	Morey et al. (90)	Self-report	All axis II disorders	Constructed from MMPI item pool
Borderline Syndrome Index	Conte et al. (91)	Self-report	Borderline personality disorder	Includes schizotypal items

[1] Benjamin (88)

diagnostic judgments is usually expressed by the kappa statistic, a measure of agreement between two raters or ratings, corrected for the possibility of agreement by chance. A kappa of 0 means agreement is strictly by chance; a kappa of 1 indicates perfect agreement. Generally, kappas below .40 are considered poor, .40 to .60 fair, .60 to .75 good, and above .75 excellent (45).

Even though borderline personality disorder is defined by explicit diagnostic criteria in *DSM-III*, the reliability of the diagnosis as made in routine clinical practice has been found to be low (k = .29) (46). This poor reliability is due, in part, to error introduced into the diagnostic process by variations in the amount and kinds of information available on which to base a diagnosis. Use of a systematic routine for gathering information—that is, a semistructured interview or questionnaire—should reduce this source of diagnostic error.

Several studies that have assessed samples of patients and persons in the community using interviews for axis II disorders have found the reliability of the diagnosis of borderline personality disorder to be high (k = .70 to .96). The only exception appears to be the multisite reliability study of the SCID-II, in which a below-average kappa of .48 was obtained at the various sites studied (First MB, personal communication, 1991). This study used the more rigorous test-retest design involving independent reinterviews of subjects rather than the joint interview design in which two raters observe the same interview. In the study by Zanarini and co-workers (39), however, test-retest reliability of the DIPD, which is very similar to the SCID-II, was found to be .85, suggesting that rigorous training of interviewers can result in very reliable diagnosis even when independent assessments are made.

Studies of the DIB have found reliability ranging from good to excellent (interrater k = .71 to .80; test-retest k = .71) (15,47). The only studies of a self-report questionnaire that involved separate administrations and categorical (as opposed to dimensional) measurement used the preliminary version of the Personality Diagnostic Questionnaire–Revised (PDQ-R) (48). The reliabilities obtained were acceptable (k = .55 t[illegible] .59) (43, 49).

Validity. Measures of the association between two diagnoses when one is considered indicative of true clinical status are sensitivity, specificity, and positive and negative predictive power. An instrument's sensitivity and specificity quantify its ability to identify true cases and noncases, respectively. Positive and negative predictive power show the proportion of putative cases and noncases, respectively, diagnosed by the instrument that are true cases and noncases according to the validity standard (50).

One measure of an instrument's validity is its ability to identify patients believed to have borderline personality disorder. Since the clinical diagnosis of borderline personality disorder has traditionally been unreliable and of debatable validity itself, it has been difficult to arrive at an appropriate standard against which to measure an instrument's performance.

Agreement between diagnoses of borderline personality disorder based on self-report instruments and those based on structured interviews is modest. Widiger and Frances (1) report kappas for the earlier version of the Millon Clinical Multiaxial Inventory (51) of .05 and .32 based on the studies of Piersma (52) and Reich and asssociates (53), respectively, and .43 for the earlier version of the PDQ-R (53). Several studies have reported that compared with interviews, self-report inventories tend to overdiagnose borderline personality disorder. When diagnoses based on the PDQ-R were compared with structured-interview diagnoses based on the SCID-II and the PDE, kappas of .53 and .46, respectively, were found (54). Using the convergence or divergence of interview results as measures of narrow and broad estimates of personality disorder, respectively, we found high sensitivity (.98 and .95) and negative predictive power (.94 and .83) for the diagnosis of borderline personality disorder based on the PDQ-R.

These results all suggest that a questionnaire diagnosis of borderline personality disorder may be a false positive, but the absence of a diagnosis by self-report is rarely associated with a diagnosis by structured interview. Self-report questionnaires, therefore, seem to have a role in the assessment of borderline personality disorder as efficient and cost-effective screening tests.

Diagnoses that are based on semistructured interviews have most commonly been compared with clinical diagnoses. For example, in revising the DIB, Zanarini and coworkers (41) used clinicians' principal axis II diagnoses as the standards. At a cutoff score of 8 (of a possible 10), the DIB-R had a sensitivity of .82, a specificity of .80, a positive predictive power of .74, and a negative predictive power of .87. The DIB-R is more effective than the DIB in discriminating patients with borderline personality disorder from patients with other types of personality disorders. The DIB was found by several investigators to be overinclusive (55,56).

Kavoussi and associates (57) and O'Boyle and Self (58) recently compared structured interviews. Kappas for borderline personality disorder measured by different instruments ranged from .18 to .62. Without a standard for comparison, it is impossible to say which instrument is "best." In searching for an appropriate validity standard for personality disorder instruments, our group (59–61) adapted Spitzer's LEAD standard (longitudinal expert evaluation using all data) (62). We found that diagnoses of borderline personality disorder made by using the SCID-II or the PDE (which agreed with each other at k=.53) did not correspond particularly well to the diagnoses of an expert clinician who was given an opportunity to closely observe patients over time and had access to a variety of informants and sources of information.

Do these results mean that structured interviews are too variable to be useful? Such a conclusion would be premature since the reliability and validity of LEAD diagnoses are unknown. The soundest conclusion that might be drawn is that no single diagnostic instrument has clearly demonstrated superiority over others and that the results of research tools should be interpreted cautiously at present. A patient who is diagnosed with borderline personality disorder by more than one instrument is more likely to be a valid case than a patient about whom the instruments disagree.

Assessment problems

The difficulty of interviewing patients suspected of having borderline personality disorder can vary widely depending on circumstances. In a setting in which a motivated patient is applying for a highly desirable and selective treatment, the task is considerably easier than in an emergency room where a sullen patient is being evaluated involuntarily after a failed suicide attempt.

In general, borderline patients are dramatic and emotional. It may be difficult to keep a patient focused or to distinguish exaggeration from fact. Every statement may be extreme, due to characteristic black-and-white and all-or-nothing thinking. Splitting may also lead to apparent contradictions. Confrontation is used as a diagnostic probe in structural interviews of borderline patients (8), but even experienced interviewers have provoked impulsive patients to walk out.

Although the approach to differential diagnosis embodied in *DSM-III* and *DSM-III-R* does not emphasize the diagnostic importance of a patient's here-and-now interactions with a clinician, an evaluation interview provides a first-hand sample of a patient's personality style that is often strongly suggestive of a diagnosis. However, four general determinations are critical in assessing most personality disorders according to *DSM-III* or *DSM-III-R* criteria: pervasiveness; inflexible, enduring pattern; blind spots or socially undesirable features; and maladaptivity and impairment (63).

Borderline personality disorder pervasively influences regulation of affects, sense of self, cognitive processes, control of impulses, and interpersonal relationships. As mentioned above, clinicians may be tempted to make a diagnosis in the face of a particularly dramatic or characteristic symptom. The manifestations of borderline personality disorder should not be limited to one particular situation or occur in relationship to only one particular person. For example, involvement in uniquely stressful circumstances, such as a physically or sexually abusive relationship, may evoke a dramatic response from many people, not just those with borderline personality disorder.

Evidence of borderline personality disorder should be observable over time. Usually, two to five years is the minimum time necessary to indicate a stable personality pattern. Frequent changes in personality style, or evolution over time, might suggest another mental or physical disorder.

Physically self-damaging acts and other evidence of impulsivity might seem too onerous for some patients to admit, especially during initial contacts with mental health professionals. Difficulties in relationships may not be seen by the patient as his or her problem but as problems caused by others. An objective informant may be of assistance, but it is unlikely that someone intensely involved with a borderline patient will be objective.

Finally, although most behaviors of persons with borderline personality disorder seem maladaptive by definition, due to extensive comorbidity of borderline personality with other disorders (see below), it is important to document distress and social and occupational impairment secondary to the personality disorder itself and distinguish it from distress due to a superimposed disorder. Longitudinal observation frequently is required so that a patient may be seen after a psychosocial crisis or after an episode of an axis I disorder has resolved or improved (60).

Comorbidity. Borderline personality disorder has been found to be associated with so many other axis I and II diagnoses that its validity as an independent diagnostic entity has been questioned (64). Resolution of this controversy awaits future research. Using the *DSM-III-R* multiaxial system, which encourages multiple diagnoses, the clinician evaluating a patient with suspected borderline personality disorder should be alert to other diagnostic possibilities.

There is ample evidence that patients with borderline personality disorder may have comorbid axis I disorders, such as mood (65–67), anxiety (68,69), substance use (69, 70), and eating disorders (69,71). Dissociative, somatoform, factitious, and impulse control disorders have also been reported (69,72,73). When warranted, such diagnoses should be made in addition to borderline personality disorder.

The incidence and nature of psychosis in borderline personality disorder has been a subject of controversy (74). Currently, psychotic symptoms occurring in patients with borderline personality disorder are believed to be transient, stress-related, "quasi-psychotic" cognitive-perceptual distortions (75), which in severity may fall short of *DSM-III-R* definitions of psychosis. Comorbid axis I syndromes may help to guide treatment selection, especially pharmacologic treatment, and to estimate prognosis (76).

Borderline personality disorder has been shown to be associated with virtually all the other axis II disorders. In a review of 13 studies, Widiger and colleagues (77) reported that borderline personality disorder covaried most highly with histrionic, antisocial, and passive-aggressive personality disorders, followed by schizotypal, dependent, avoidant, narcissistic, and paranoid personality disorders. In an unpublished study (Oldham JM, Skodol AE, Kellman HD, Hyler SE, Rosnick L, Davies M, 1991), we found that when diagnoses were made using the SCID-II, borderline personality disorder and antisocial personality disorders were ten times more likely to occur together than for either to occur alone; histrionic and passive-aggressive personality disorders were four to five times more likely to occur with borderline personality disorder as diagnosed by either the SCID-II or the PDE.

Comorbid personality disorders influence the assessment of borderline personality disorder. Histrionic patients may exaggerate in reporting behaviors or traits, antisocial patients may lie, and passive-aggressive patients may resist efforts to evaluate them. Perry (78) has shown that patients with both borderline personality disorder and antisocial personality disorder had less depression, on a lifetime basis, than [illegible]tients with borderline person[illegible] disorder alone. Comorbid axis II conditions, therefore, may also influence course and outcome in borderline personality disorder.

Significance and conclusions

Establishing a psychiatric diagnosis is not an end, but a means. To be justified, a diagnosis should convey information valuable in planning treatment or predicting outcome.

Personality disorders in general have been found to adversely affect the treatment outcome of a number of axis I disorders, including major depression, panic disorder, and obsessive-compulsive disorder (79). Less is known about individual personality disorders, but borderline personality disorder appears to follow this general rule.

However, newer psychopharmacologic agents, such as fluoxetine, have shown promise for treating both the depressive and impulsive symptoms of borderline personality disorder (80,81). New psychothe[illegible]peutic strategies are also being dev[illegible]oped (82). Long-term follow-up studies, such as those of McGlashan (83), Stone and associates (84), and others, have shown that borderline personality disorder may persist for years but may also ameliorate over the long run, especially with treatment. Maximizing a patient's chance for recovery begins with careful assessment and diagnosis to ensure that all potentially relevant diagnostic factors have been considered.

Given the problems and challenges inherent in making an accurate diagnosis of borderline personality disorder, and the importance of doing so, we offer the following guidelines to assessment.

- Clinicians should be aware that concepts underlying the term borderline overlap but are not identical. Clinicians should understand what information is needed to make the diagnosis according to the concept of interest.
- Clinicians using *DSM-III-R* criteria should make sure that the [illegible]quired features are pervasive, inflexible, and enduring and that they

cause impairment in functioning.

- Self-report and semistructured instruments for diagnosing borderline personality disorder can be useful in clinical settings, but they are not necessary if accurate information needed for diagnosis can be gathered with a standard clinical interview.
- Comorbid axis I disorders, such as mood, anxiety, or psychoactive substance use disorders, should be identified in patients with borderline personality disorder; comorbid syndromes may help guide treatment.
- Clinicians should be alert to other personality disorders and traits, which may affect assessment and course in patients with borderline personality disorder.

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Biological and Pharmacological Aspects of Borderline Personality Disorder

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Biological and psychopharmacological research focusing on patients with a DSM-III-R diagnosis of borderline personality disorder suggests that the disorder may encompass three clusters of symptoms—affective instability, transient psychotic phenomena, and impulsive aggressive behavior—that have different underlying biological substrates that respond to different classes of pharmacological agents. Affective instability, which may be related to abnormalities in the brain's adrenergic and cholinergic systems, appears to respond to agents such as lithium and carbamazepine that are effective in treating major affective disorders. Abnormalities in central dopaminergic systems may underlie transient psychotic symptoms. This relationship is consistent with reports of beneficial effects of low-dose neuroleptics in treating some borderline patients. Abnormalities in central nervous system serotonergic functioning appear to underlie impulsive aggressive behaviors. These behaviors may respond to serotonergic agents such as fluoxetine.

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The pharmacological treatment of patients with borderline personality disorder can be difficult and extremely frustrating for both psychiatrist and patient. The *DSM-III-R* diagnosis of borderline personality disorder describes a heterogeneous group of patients, complicating the design and interpretation of studies about such treatment.

There is growing evidence that personality psychopathology does not occur as discrete categorical phenomena, but rather on a continuum with normal personality traits (1). Classifications of disorders based on dimensional criteria offer an advantage over classifications based on categorical definitions because clusters of symptoms can be more readily correlated with biological measures or treatment responses than can discrete symptoms.

In this paper we describe three clusters of psychopathology that have been observed in biological and pharmacological studies of patients with borderline personality disorder. The clusters are affective instability, transient psychotic phenomena, and impulsive aggressive behavior. We review evidence for the biological factors that may underlie these clusters and correlate these factors with strategies for psychopharmacologic treatment

Biological studies

Affective instability. The prominent symptoms of a *DSM-III-R* diagnosis of borderline personality disorder include marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days. These symptoms may also occur in patients with other disorders of mood such as dysthymia, cyclothymia, hypomania, and bipolar disorder (2). Hence, it is likely that the biological abnormalities found in patients with axis I mood disorders may also be found in borderline patients.

Some studies have suggested a relationship between severity of major depression and dysregulation of the hypothalamic-pituitary axis as measured by nonsuppression of plasma cortisol in response to orally administered dexamethasone (3). However, in borderline patients these values appear to reflect the effect of comorbid major depression rather than the underlying personality disorder, since patients with personality disorder who do not also have major depression do not show abnormal results on the dexamethasone suppression test (4–6).

Patients with affective disorders also have abnormal patterns in the response of thyroid-stimulating hormone to intravenous thyrotropin-releasing hormone (TRH) (7). However, as in the studies using the dexamethasone suppression test, borderline patients' abnormalities in response to TRH appear to be due to comorbid major depression (8–10). At this time, then, specific biologic markers underlying the affective symptoms of borderline personality disorder have not been found.

A potential index of affective disturbance in borderline patients is the behavioral response to central nervous system stimulants such as amphetamine and methylphenidate, which are known to produce elevations in mood. However, research on the effect of intravenous stimulants on borderline patients has produced conflicting results. Some studies have noted marked dysphoria in response to the stimulants (11); others have reported improvement in mood

(12). Hence, it appears that stimulants may improve affective symptoms in some borderline patients but may worsen these symptoms in others.

The brain's cholinergic systems may also play a role in the regulation of affect. In patients with major mood disorders, the cholinergic system appears to be highly sensitive to agents such a physostigmine, which increase central cholinergic activity and can produce depressive symptoms (13). These findings suggest that cholinergic dysfunction might also underlie affective instability in borderline patients. The observation that borderline patients appear to be more sensitive than control subjects to the effects of cholinergic system agonists in the experimental induction of REM sleep supports this possibility (14).

Transient psychotic phenomena. Many borderline patients experience brief, stress-related psychotic symptoms, although these symptoms are not included in the *DSM-III-R* criteria for a diagnosis of borderline personality disorder (15). Studies of patients with axis I psychotic disorders have suggested biochemical models that may also apply to the occurrence of mild psychotic symptoms in borderline patients. Plasma levels of homovanillic acid, the major metabolite of dopamine, have been shown to have a positive correlation with global severity of psychosis in schizophrenic patients (16). A recent study of patients with a variety of *DSM-III-R* personality disorders found a positive relationship between plasma homovanillic acid and number of psychotic symptoms, such as magical thinking, illusions, and ideas of reference (17). This finding suggests that dopaminergic dysfunction may be involved in the psychotic symptoms seen in severely ill borderline patients.

Impulsive aggressive behavior. Impulsivity, intense anger, and self-damaging acts constitute three of the eight *DSM-III-R* diagnostic criteria for borderline personality disorder. Some studies assessing *DSM* criteria have suggested that impulsivity, self-damaging acts, and unstable interpersonal relationships best differentiate patients with borderline personality disorder from those with other personality disorders (18).

The major neurotransmitter implicated in impulsive, aggressive behavior and in suicidal behavior is serotonin (5-HT) (19). In two studies of patients with mixed personality disorders, cerebrospinal fluid levels of 5-hydroxyindolacetic acid (5-HIAA), the major metabolite of serotonin, correlated inversely with life history of aggressive behavior and suicide attempts (20,21). An inverse relationship between history of a serious suicide attempt and level of 5-HIAA was also found in a study of female borderline patients (22).

In other studies, the level of prolactin response to serotonin receptor agonists, an indirect measure of the level of sensitivity of serotonin receptors, correlated inversely with measures of behavioral aggression (23–26). In one study, patients who had shown impulsivity, intense anger, or self-damaging behavior had reduced prolactin release regardless of whether they met criteria for a *DSM-III* diagnosis of borderline personality disorder (23).

While abnormalities in serotonin functioning clearly play an important role in impulsive, aggressive, and suicidal behavior, other research suggests that these behaviors may be controlled by more than one neurotransmitter. Studies that have reported a relationship between reduced cerebrospinal fluid concentrations of homovanillic acid and history of suicidal behavior support the hypothesis that central dysfunctions in the catecholamine system producing abnormal levels of dopamine may affect impulsive aggressive behaviors (19, 27).

Psychopharmacologic studies

Affective instability. Before *DSM-III* criteria were developed, patients who suffered from rapidly shifting and intensely felt affective states were often given a diagnosis of "emotionally unstable character disorder" (28). Psychopharmacologists recognized that these patients responded better to lithium than to placebo or imipramine. This response suggests that some borderline patients suffer from a subclinical affective disorder that is mediated by biological mechanisms similar to those that mediate bipolar disorder or cyclothymia.

In several early studies, patien with diagnoses of pseudoneurot schizophrenia, a precursor to the diagnosis of borderline personality disorder, appeared to respond better to agents that enhance catecholamine function, including stimulants, imipramine, and tranylcypromine, than to placebo or to agents such as chlorpromazine and trifluoperazine that reduce catecholamine function (29,30). Patients with hysteroid dysphoria, a syndrome that involves repeated episodes of abruptly depressed mood in response to feeling rejected, appear to benefit from monoamine-oxidase-inhibiting antidepressants (31). A recent study comparing the effects of phenelzine and imipramine in patients with atypical depression found that phenelzine was more effective in patients who also met *DSM-III* criteria for borderline personality disorder (32). Thus it is possible that monoamine oxidase inhibitors may be more efficacious than tricyclic antidepressants in treating affective instability in borderline patients.

In one of the most comprehensive studies of pharmacotherapy of borderline personality disorder to date, four different agents were compared with placebo in 16 female patients with a *DSM-III* diagnosis of borderline personality disorder (33). The four agents were trifluoperazine, tranylcypromine, carbamazepine, and alprazolam. Patients received each agent for six weeks followed by a two-week period during which they received a placebo before being started on another agent. Tranylcypromine was most effective in improving dysphoria, while carbamazepine was most effective in diminishing episodes of impulsive behavior and behavioral dyscontrol.

Trifluoperazine was somewhat more efficacious than placebo in improving global ratings of treatment response but did not appear to affect any particular target symptom more than others. Finally, alprazolam was associated with a greater increase in behavioral dyscontrol, compare with placebo. Improvements in mood associated with agents such as monoamine oxidase inhibitors that enhance catecholamine function support the hypothesis that affective symptoms in patients with borderline personality disorder may reflect a variant of axis I affective disorders and may involve dysregulation of catecholamine neurotransmission.

Transient psychotic phenomena. Many studies have reported that low doses of neuroleptics are mildly to moderately effective in improving the global status of patients with borderline personality disorder (34–37). Some of these studies suggest further that the neuroleptics have specific efficacy in treating mild psychotic symptoms, such as suspiciousness, ideas of reference, odd communication, and social isolation, as well as impulsive behavior and hostility. Positive effects on some measures of depression and anxiety have also been found, but a decrease in troubling psychotic symptoms may have accounted for improvements in subjective measures of depression and anxiety.

In a controlled study, the efficacy of thiothixene compared with placebo was examined in 50 patients who had a *DSM-III* diagnosis of either borderline or schizotypal personality disorder (38). In addition, all patients had a history of a brief psychotic episode. Compared with patients who received placebo, patients who received thiothixene had significantly lower scores on Symptom Checklist (SCL-90) measures of psychoticism, illusions, ideas of reference, and phobic anxiety. Unlike subjects in previous studies, however, patients treated with thiothixene had no change in symptoms of depression.

Another controlled study compared haloperidol and amitriptyline to placebo in 90 patients with a diagnosis of borderline personality disorder made using the Diagnostic Interview for Borderlines (39). Haloperidol was superior to placebo and amitriptyline in relieving a variety of psychotic symptoms. Variables predicting favorable response to haloperidol included severe schizotypal symptoms, hostility, and suspiciousness. Results of these studies of antipsychotic medications known to affect dopamine functioning support a relationship between abnormalities in dopamine functioning in the brain and psychotic symptoms in patients with borderline personality disorder.

Impulsive aggressive behavior. In addition to stabilizing affect, lithium has been found to decrease impulsive and aggressive behaviors in various populations of patients. A study comparing lithium, desipramine, and placebo in patients with borderline personality disorder found lithium to be superior to desipramine in improving global measures of behavior (40). In other studies, lithium was effective in suppressing impulsive aggressive behaviors in prison inmates (41,42). The mechanism of these effects is unknown, although lithium's ability to enhance presynaptic serotonergic transmission may play a role (43).

Although correlations between behavioral traits, biology, and drug therapy are useful as a guide in treating borderline patients, many other complicating factors must be taken into account.

In at least three open trials, serotonergic reuptake inhibitors such as fluoxetine have been found to reduce global psychopathology and impulsive aggression in patients with borderline personality disorder (44–46). In one study, fluoxetine was also found to reduce depressive symptoms significantly (46). However, the drug had mixed effects on hostility and psychoticism and no effect in relieving anxiety or interpersonal sensitivity. In another nonblind study of borderline and schizotypal patients, a 12-week trial of fluoxetine was associated with a significant decrease in self-injurious behavior (47). Clearly, more study of the efficacy of serotonergic reuptake inhibitors in treating patients with borderline personality disorder is needed.

There is evidence that neuroleptics may reduce suicide proneness in patients with severe personality disorders who have made recurrent suicide attempts (27). In addition, as noted earlier, neuroleptics have been shown to reduce hostility in some borderline patients. While neuroleptics have been used to treat impulsive aggressive behavior, it is not clear whether antiaggressive effects are related to dopaminergic blockade or to the fact that neuroleptics may act as sedating agents.

Selecting treatment

The research we summarized suggests that the various clusters of symptoms in borderline personality disorder—affective instability, transient psychotic phenomena, and impulsive aggressive behavior—may be associated with different underlying biological abnormalities. In turn, some medications may be more effective than others in treating each of the symptom clusters. For example, abnormalities in the dopamine system seem to underlie illusions, paranoia, ideas of reference, and other mild psychotic symptoms. These symptoms appear to respond preferentially to low doses of neuroleptics, for example 1 to 2 mg of haloperidol or its equivalent, which act on brain dopamine systems. These medications are best used for relief of acute, stress-related symptoms, but may not be preferred for long-term use in borderline patients due to the risk of extrapyramidal side effects such as tardive dyskinesia.

Serotonergic dysfunctions seem to underlie impulsive, aggressive, and self-destructive behaviors. Agents such as lithium and fluoxetine that have serotonergic properties may be best suited for treating these behaviors. Finally, the mechanisms underlying affective instability in borderline patients appear to be related to those than operate in axis I affective disorders. The mechanisms include disruption in catecholamine and cholinergic functioning in the limbic system. Medications such as lithium and carbamazepine, which affect these systems, may be most effective in reducing mood lability in borderline patients. Monoamine oxidase inhibitors are more effective than tricyclic antidepressants in treating the affective disturbances that accompany borderline personality disorder.

Although correlations between behavioral traits, biology, and pharmacotherapy are useful as a guide in treating borderline patients, many other complicating factors must be taken into account. For example, the modes of action of currently available medications are not specific. Lithium has many modes of action, including stimulating transmission of serotonin. Lithium also reduces catecholaminergic functioning. Carbamazepine has membrane-stabilizing effects and has also been reported to increase plasma levels of tryptophan, a precursor of serotonin (48).

Agents that enhance catecholamine functioning, such as tricyclic antidepressants, may stabilize a patient's mood but may also lead to increased agitation and perhaps behavioral dyscontrol. It is hoped that medications available in the future will be more specific in their mechanism of action in the brain, leading to more specific and predictable pharmacologic responses in patients. Some currently available (or soon to be available) medications, including serotonin uptake blockers such as fluoxetine, paroxetine, sertraline, and fluvoxamine and serotonin agonists such as buspirone, gepirone, and eltopraine have specific biological effects that may be easier to correlate with behavioral responses.

Researchers and clinicians who are interested in the biological aspects of personality disorders must also be aware of the interaction between biological predispositions and environment in the development of personality pathology. Obviously, the way in which a particular physiologic abnormality manifests itself is mediated by the interaction of the individual and others in the environment—family members, peers, teachers, and entertainers.

When an affectively unstable person responds dramatically to seemingly trivial rejection or to fear of abandonment, others may blame the person for not having more control over his or her emotions. Unable to develop adequate coping skills to help regulate these shifts in affect, the person may adapt by acting out to relieve tension or to obtain a helping response from others. Such patients may have difficulty developing an adequate internal representation of the self because they are likely to receive messages from significant others that contradict their own self-assessment. A combination of these innate and learned responses could be involved in the development of borderline personality disorder.

Very few borderline patients will respond to medications alone. Rather, treatment of borderline personality disorder with medication should be seen as a means of controlling disabling symptoms in the context of an overall treatment plan that includes individual, group, family, and behavioral therapy. However, additional research leading to a better understanding of the biology of these disorders will allow development of more specific pharmacological treatments and improved psychotherapeutic techniques that can be modified to suit an individual's innate temperament.

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Standardized Approaches to Individual Psychotherapy of Patients With Borderline Personality Disorder

M. Tracie Shea, Ph.D.

Recent developments in individual psychotherapy for patients with borderline personality disorder include psychodynamic, interpersonal, behavioral, and cognitive treatments. The author provides an overview of standardized treatment approaches—that is, modes of treatment that have a clear theoretical rationale and specific strategies and techniques—for borderline personality disorder. Evaluations of the efficacy of these approaches are discussed. Although there is little empirically based knowledge about the effectiveness of these treatments, their adaptation for the specific treatment of borderline personality disorder represents an important step for treatment and research in this area.

For patients with borderline personality disorder, individual psychotherapy is probably the most frequently used treatment modality. Early treatment approaches were primarily derivatives or modifications of psychoanalysis or psychoanalytically oriented psychotherapy. In recent years, alternative approaches, including behavioral and cognitive treatments, have been developed.

An important development in the field of psychotherapy is a movement toward clearer definition, or standardization, of treatments, which has been largely driven by efforts to evaluate the effectiveness of treatments for specific disorders. Detailed descriptions of the theoretical rationale, treatment goals, and specific therapeutic strategies and techniques, often referred to as "manuals," now exist for a number of psychotherapeutic treatment approaches. Early efforts in this direction were focused primarily on *DSM-III* axis I disorders, such as anxiety and depression, and there are now such manuals for the treatment of personality disorders.

The definition and diagnosis of borderline personality disorder has been a subject of much debate. Most of the more recent approaches to treatment have defined borderline personality disorder according to *DSM-III*, which uses a descriptive, objective approach with operationalized criteria related to affective instability, impulsivity, and self-destructiveness. Psychoanalytic approaches, in contrast, have tended to view borderline personality in terms of personality organization or ego functioning. The latter approach emphasizes intrapsychic structure, including the use of primitive defense mechanisms, as opposed to the more observable behavioral criteria and captures a broader range of patients than those defined by *DSM-III*. Many of the patients diagnosed by the psychostructural method would not meet *DSM-III* criteria, which identifies a more severely symptomatic subgroup of patients.

This paper provides an overview of the different forms of individual psychotherapy that have been developed or modified for use with patients with borderline personality disorder. Particular emphasis is placed on approaches that have been standardized. Psychodynamic, interpersonal, behavioral, and cognitive treatment approaches are included. Results of studies of the effectiveness of these treatment approaches are summarized. The large and clinically rich literature on various aspects of psychoanalytic theory and techniques is beyond the scope of this paper.

Treatment approaches

Psychoanalytically oriented treatments

Variations of psychoanalytic approaches can be broadly categorized into supportive and expressive forms of therapy. Aronson (1) has recently written a comprehensive historical review of the evolution of psychoanalytically oriented psychotherapy for borderline patients.

Supportive approaches. Supportive approaches evolved from the psychoanalytic tradition in the 1940s as a result of concern about limitations and possible dangers of the traditional psychoanalytic approaches for borderline patients. Advocates of the supportive approach stressed the need for different goals for these patients, such as improvement of adaptive functioning, rather than change in intrapsychic structure or other aspects of personality.

Supportive approaches focus on supporting and strengthening defenses and avoiding regression in treatment. Increased intensity of the transference relationship is viewed as potentially dangerous to the patient. Treatment is structured, with clear goals, much activity and direction from the therapist, and a focus on current problems and functioning.

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Relationship factors are emphasized, including warmth, consistency, and availability of the therapist. Interpretations are generally avoided. Although Kernberg (2) is primarily an advocate of expressive therapy with borderline patients, he has developed a manual for supportive psychotherapy.

Expressive approaches. Largely influenced by Kernberg's work, the 1970s were marked by a shift away from supportive psychotherapy and back to more insight-oriented, interpretive techniques, more intensive therapy, and more ambitious treatment goals. Competing theories and models emerged, differing primarily in their emphasis on either conflict or deficit as key to borderline pathology. The different expressive approaches are similar in their use of a modified psychoanalytic approach, characterized by interpretive and uncovering techniques, the therapist's active role, a focus on here-and-now issues, and an emphasis on countertransference and limit setting (1).

Kernberg (3) has provided a detailed description of his expressive psychotherapy. Goals of the treatment include increased impulse control, anxiety tolerance, ability to modulate affect, and ability to develop stable, satisfying, and intimate relationships. Kernberg's conceptualization of borderline pathology emphasizes the dissociated, "split-off" aspects of the patient's internalized perceptions of self and others and the affect associated with these perceptions. Also emphasized are primitive defense mechanisms, such as splitting, which are used to maintain separation of aggressive from loving feelings and perceptions.

Treatment strategies are designed to integrate the dissociated feelings and perceptions and increase the patient's ability to experience self and others in a more realistic and integrated fashion. This goal is accomplished by repeated identification and clarification of the dissociated aspects and states as they appear in the relationship with the therapist. Defenses that maintain the dissociations and split-off states are also repeatedly interpreted and analyzed.

Efficacy. There are no controlled outcome studies of any of the psychoanalytically oriented treatments for borderline personality disorder. Naturalistic studies have been conducted, including the Menninger study (4) and more recent studies reported by Stone (5), Gunderson and colleagues (6,7), and Skodol and colleagues (8).

The Menninger study suggested a possible advantage of expressive treatment, combined with environmental structuring, compared with a supportive treatment approach for patients with borderline personality organization. The study by Waldinger and Gunderson (6) also suggested that for moderately impaired borderline patients who remain in treatment, intensive psychotherapy may be helpful (6). However, findings from most of these studies raise serious questions about the feasibility of long-term treatment of borderline patients, since many if not most patients fail to complete even six months of treatment. Patients who remain in treatment and show improvement may well be a higher-functioning subsample.

A pilot and feasibility study is currently under way to develop the methodology necessary to implement a controlled trial of Kernberg's expressive therapy (9). The treatment has been operationalized in a manual, a scale has been developed to assess adherence to the treatment techniques, and measures are being developed for therapist, patient, and process variables of interest (3,10). Preliminary findings from 31 patients suggest dropout rates comparable to those reported in other studies (39 percent by 12 weeks). Patients who completed six months of treatment showed improvement in some aspects of functioning. The continued work of this group should provide valuable data about the efficacy of psychoanalytically oriented expressive psychotherapy for patients with borderline personality disorder.

Interpersonal approaches

Given that maladaptive interpersonal behavior is a critical aspect of borderline personality disorder, an approach that focuses explicitly on interpersonal interactions is clearly relevant. Some interpersonal theorists and researchers have begun to systematically apply their models to the axis II disorders, including borderline personality disorder. Benjamin (11,12), for example, has begun to outline a treatment approach based on her model of interpersonal behavior—structural analysis of social behavior (SASB). SASB is a system for classifying interpersonal behavior based on three dimensions: the focus of the behavior, that is, a focus on the other or on the self; affiliation, or the degree of friendliness or hostility of the behavior; and interdependence, or the degree of dominance or submission, and autonomy.

Benjamin has described each of the axis II personality disorders, including borderline personality disorder, in terms of the interpersonal patterns derived from SASB (11). The SASB interpersonal summary of borderline personality disorder emphasizes an intense fear of abandonment and a desire for protective nurturance; friendly dependence on a nurturer, which becomes hostile control if the caregiver fails to deliver enough; a belief that the provider likes dependency and neediness; and an internal response of vicious self-attack triggered by happiness or success (13).

Specific kinds of developmental experiences are thought to be associated with these affects and behaviors. Developmental factors include a chaotic environment, traumatic abandonment experiences, attack by important others in response to the individual's expression of self or happiness, and nurturance in response to sickness (11).

Principles of a treatment approach based on the SASB model, SASB-directed reconstructive learning therapy, have been outlined (13). The treatment stresses identification of the patient's interactive patterns and associated wishes and fears and understanding of the patterns' origins and current purposes. Six phases of treatment are identified: the development of a collaborative relationship between patient and therapist; insight, or identification of the patient's interactive patterns and where they came from; facing of unconscious wishes and fears; grief after the decision to give up the old ways; panic after implementation of the decision to change; and emergence of a new self.

Efficacy. The interpersonal treatment approach has only recently been described, and no data about its effectiveness in treating any of the personality disorders are available.

Behavioral approaches

Linehan (14) and Turner (15) have developed comprehensive treatment approaches for borderline personality disorder. Linehan's approach, called dialectical behavior therapy (DBT), is the most fully developed. It is conducted in both individual and group formats and incorporates a range of traditional behavioral strategies, as well as some unique strategies specifically relevant to borderline personality disorder.

Linehan emphasizes the borderline patient's inadequate affect regulation, which is largely due to biological factors and a childhood environment characterized by an absence of emotional validation. Behavioral strategies and techniques define explicit goals and targets in behaviorally operational terms and use traditional behavioral techniques, such as exposure techniques, skill training, contingency management, and cognitive modification. Four sequential group treatments are provided over the course of one year; the group treatments focus on interpersonal effectiveness, emotional control, and distress tolerance.

Treatment targets in individual DBT are defined in order of importance, including suicidal behaviors; behaviors interfering with the conduct of therapy; avoidance and escape behaviors; acquisition of behavioral skills, such as regulation of emotions, interpersonal effectiveness, distress tolerance, and self-management; and other goals unique to the individual patient. The focus of treatment shifts to other targets when problems in those areas arise (16). Treatment also emphasizes attention to the relationship between the therapist and patient.

Efficacy. Linehan (17) has reported results of a one-year trial of DBT, compared with treatment as usual, for 44 severely dysfunctional, parasuicidal women with borderline personality disorder as defined by *DSM-III*. She found that patients in the DBT group had a much lower attrition rate (16.7 percent) than patients receiving the usual treatment (58.3 percent). Linehan also found that for DBT-treated patients the frequency and severity of parasuicidal behavior and the number of days of inpatient hospitalization were significantly reduced. The two treatment groups did not differ, however, on measures of depression, hopelessness, suicidal ideation, or reasons for living.

Cognitive therapy

Cognitive therapy was developed for the treatment of depression and later modified for use with other axis I disorders, including anxiety disorders (18,19). Several cognitive theorists and clinicians have begun to write about their conceptualizations of borderline personality disorder and their use of cognitive treatment approaches with these patients (20–23). Beck (24), the developer of cognitive therapy, has recently written a treatment manual for cognitive therapy of personality disorders, including borderline personality disorder.

Cognitive and behavioral treatment approaches for borderline personality disorder overlap to some extent, as behavioral approaches often include cognitive techniques, and cognitive approaches use behavioral strategies. However, there are important differences in the focus of each approach and in assumptions about the primary mechanisms of pathology. Behavioral approaches place a primary emphasis on learning principles and patterns of reinforcement. Cognitive therapy assumes that maladaptive and distorted beliefs and cognitive processes underlie the symptoms and disturbances in affect and behavior. The primary strategies and techniques of cognitive therapy are thus directed toward identification and correction of the distorted beliefs, assumptions, and maladaptive cognitive processes.

Beck (24) has described three key assumptions typical of borderline patients that appear to play a central role in the disorder: the world is a dangerous place; I am powerless and vulnerable; and I am inherently unacceptable. The belief of helplessness in a hostile world together with the belief that a source of security is absent results in a vacillation between autonomy and dependence.

Another key cognitive feature of borderline patients described by Beck is dichotomous thinking, or the tendency to evaluate experiences in terms of mutually exclusive categories such as good or bad, love or hate, and so forth. This tendency forces extreme evaluations of events, accompanied by extreme emotional responses and actions, and is believed to contribute to the abrupt mood swings and dramatic shifts in behavior characteristic of persons with borderline personality disorder.

Although many of the standard cognitive techniques are included in the treatment of borderline patients, certain modifications are required. The dysfunctional beliefs of patients with personality disorders are more persistent because they are more deeply ingrained in their cognitive organization. Changing the dysfunctional thought patterns requires considerably more time and effort than is necessary for axis I disorders.

Thus what Beck refers to as the "characterologic phase" of treatment geared toward structural change is incorporated in therapy. There is an increased emphasis early in the treatment on building a relationship between the therapist and patient, particularly on the development of trust. Transference reactions are viewed as a rich source of material for uncovering dysfunctional thoughts and assumptions. Experiential techniques, such as the use of imagery and the reliving of childhood events, are considered to be particularly effective, since the affective experience induced by such techniques is important in bringing about cognitive change.

Because of the intensity of the borderline patient's beliefs, identifying, testing, and changing underlying assumptions requires acceptance of a much slower pace of change and a heavier reliance on behavioral experiments to test the validity of the beliefs. In addition to focusing on the underlying assumptions and dichotomous thinking, interventions are used to increase control over emotions, improve impulse control, and strengthen the patient's sense of identity.

Efficacy. Little is known about the efficacy of cognitive therapy for borderline patients. No controlled studies are available, and existing findings are based primarily on clinical experience and case reports. Controlled studies are clearly needed to determine the possible effectiveness of this treatment approach with borderline patients.

Discussion

The treatment approaches described represent a significant advance in the articulation and expansion of individual psychotherapies for patients with borderline personality disorder. They are characterized by clear explication of the theoretical rationale and well-developed conceptualization of borderline pathology as well as by descriptions of specific strategies and techniques.

Despite the differences in theories and techniques, these approaches have several features in common, which represent critical aspects of any form of treatment for borderline patients. All approaches, for example, stress the importance of careful attention to the relationship with the patient. This focus is particularly notable for the behavioral and cognitive approaches because they typically do not place as much emphasis on relationship issues. Establishing a trusting and collaborative relationship with borderline patients, which evolves more easily and requires less effort with many other kinds of patients, is itself a therapeutic accomplishment. Features of the therapeutic process that promote a strong therapeutic alliance are of critical importance in the success of any form of treatment with these patients.

A second common feature is the therapist's active role. While activity on the part of the therapist is typical of behavioral and cognitive therapies, the psychodynamic approaches also underscore the importance of the therapist's active role in treating these patients. This emphasis reflects the patients' strong needs for structure and support, particularly in the context of interpretations and confrontations.

All of these approaches focus on the need to set limits. While most approaches stress limit setting as important for the patient's development, at least one author (Linehan) has pointed out the importance of setting limits to prevent the therapist from feeling frustration and resentment. Limit setting is considered essential to prevent the disruption of the treatment.

Any form of treatment for borderline patients requires flexibility in its implementation because of the shifting states and crises typical of these patients. This flexibililty can be managed even within standardized approaches. In Linehan's dialectical behavior therapy, for example, the need for flexibility is built into the treatment by inclusion of a hierarchy of targets that shift according to the immediate status and problems of the patient.

Finally, regardless of the treatment approach, the therapist needs considerable skill, particularly including the ability to deal with the difficult countertransference issues often provoked.

Very little is known about the effectiveness of these treatments for borderline personality disorder. Systematic descriptions of the various approaches and development of measures of the therapist's competence and adherence to the treatment will allow increasingly rigorous research on efficacy. Investigations of strategies and techniques aimed at increasing compliance, particularly keeping patients in treatment, would be valuable. An important part of such investigations would be determining factors that promote the development of the therapeutic alliance. Other important targets for study include the ability of these treatments to reduce the life-threatening and self-destructive behaviors typical of borderline patients, an approach that Linehan has successfully taken in evaluating the efficacy of DBT.

Finally, an important question for all treatment approaches concerns reasonable goals of treatment. How much improvement can be expected? Linehan has found that one year of DBT results in a signficant reduction of self-destructive behaviors but has little effect on depression and hopelessness. Would a longer period of treatment result in improvement in the latter areas as well? If so, how much improvement? Can these patients expect elimination of serious depression or expect to be able to achieve stable and satisfying interpersonal relationships?

Clearly, these questions have no simple answers, and there is likely to be a range of outcomes for different patients. The identification of factors that are associated with different levels of outcome is another important question for research.

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Multiple Personality Disorder: A Challenge to Practitioners

Thomas J. Giancarlo

ABSTRACT: *Multiple personality disorder is becoming better understood and thus more treatable Because clinicians often treat child and adult victims of physical and sexual abuse, a potential trigger of multiple personality disorder, it is imperative that they become more skilled in diagnosing and treating this disorder*

MUCH HAS BEEN WRITTEN about multiple personality disorder in the past 10 years. Forms of multiple personality disorder have appeared throughout history; often it was considered proof of demonic possession. Reported cases go back as far as 1646 (Bliss, 1980). Numerous cases have been reported since that time, as students of the human psyche became interested in the mechanisms of the mind, especially dissociation. In the early part of the 20th century, however, the psychiatric profession showed less interest in dissociation and multiple personalities as a result of the psychoanalytic model's emphasis on repression. Moreover, the diagnosis of schizophrenia was used more often in the United States in the 1920s, resulting in a decline in the diagnosis of multiple personality. Bleuler stated that "schizophrenia produces different personalities existing side by side" (Rosenbaum, 1980, p. 1384). The lay public's view of schizophrenia as being a form of "split personality" evolved during this period (Bernheim & Levine, 1979). It wasn't until the 1970s that interest in dissociation and multiple personality was renewed, partly as a result of the publication of *Sybil* (Schreiber, 1974)—a book that reintroduced the public and the mental health profession to multiple personalities.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) (American Psychiatric Association, 1987) defines multiple personality disorder as follows:

> A. The existence of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and one's self.)
>
> B. Each of these personality states at some time, and recurrently, takes full control of the individual's behavior (p. 106).

This definition is different from the 1980 edition of the manual (American Psychiatric Association, 1980), which stated that "each individual personality is complex and integrated with its own unique behavior patterns and social relationships" (p. 259). Putnam (1989a) reminds us that many secretive alter personalities actively avoid the "social relationships" mentioned in this definition. In addition, many of the alter personalities are "personality fragments," that is, entities with a persistent sense of self and a characteristic, consistent pattern of behavior but "with a more

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limited range of function, emotion, or history" (Kluft, 1984b, p. 23). These fragments might appear only in specific contexts, such as a guardian personality that emerges to protect the body from injury or threat. However, as Lowenstein (1989) pointed out, current thought focuses less on the personalities as reified constructs and more on multiple personality disorder as a complex dissociative process, only one aspect of which is the creation of alter personalities.

Etiology

Several models have attempted to describe the development of multiple personality disorder. Kluft's (1984a) four-factor theory posits that a person is a candidate for multiple personality disorder if he or she is sufficiently influenced by the following factors:

1. He or she has the biological and psychological potential to disassociate.
2. He or she is exposed to traumatic experiences that overwhelm normal means of coping with stress, thus causing the person to dissociate.
3. These dissociations assume forms such as the development of imaginary companions.
4. Significant others do not protect the individual from overwhelming stimuli and/or do not provide adequate soothing and other restorative experiences (e.g., a parent who does not recognize a child's stress and trauma and does not comfort the child in some way).

Putnam (1989a) believes that "we are all born with the potential for multiple personalities and over the course of normal development we more or less succeed in consolidating an integrated sense of self" (p. 51). He explains that in infancy our behavior is organized into a series of discrete states. Over time, and with the help of healthy caretakers, we learn to modulate the transitions between these behavioral states. Our success with this process allows us to sustain a given state longer and to present a "more unified sense of self across contextual changes" (p. 51).

Children are able to more easily enter dissociative states than are adults. Children are able to fantasize and to project feelings, motives, and thoughts onto objects such as dolls. An extension of this is the development of imaginary companions. Imaginary companions are often seen in normal children. However, many researchers believe that in children who are predisposed to multiple personality disorder, imaginary companions may be the prototypes for alter personalities. It may be that these imaginary companions are endowed with certain characteristics and linked to specific types of circumstances, feelings, or experiences. Similar experiences occurring over time reinforce this process, building a kind of "life history" for that personality part (Putnam, 1989a). Putnam (1989a) further states that "the number of different alter personalities in adult MPD victims is significantly correlated with the number of different kinds of trauma suffered in childhood, suggesting that a child enters into different dissociative states depending upon the circumstances" (p. 54).

In general, then, a child with potential and predisposition for dissociation may use that naturally occurring psychological mechanism to cope when exposed to overwhelming stress. If similar circumstances recur, the child's dissociation may solidify into an alter personality system, especially if significant caretakers in that child's life fail to relieve that stress or, worse, contribute to the continuation or recurrence of that stress.

In a National Institute of Mental Health study of 100 cases of multiple personality disorder, Putnam, Guroff, Silberman, Barban, and Post (1986) found that 97% of the cases reported significant childhood trauma, 68% reported incest, 85% reported sexual abuse, and 80% reported physical abuse. Confinement abuse was common. In addition, various forms of emotional abuse were commonly reported, including threats of violent punishment or actual abuse of siblings or pets in the presence of the child. Approximately 40% reported witnessing a violent death. Clearly, the vast majority of persons with multiple personality disorder grew up in highly dysfunctional families where violence was common.

Diagnosis

The classic presentation of multiple personality disorder is a client who is depressed, anxious, with blunted affect, a constricted range of feelings, often guilt ridden and masochistic, suffering both psychological and physiological symptoms, as well as time loss or distortion (Kluft, 1984a). Prior to being diagnosed with multiple personality disorder, these clients have usually been in and out of the mental health system for many years (seven years on average) (Putnam et al., 1986) and have received several different diagnoses, for example, depression, schizophrenia, manic-depressive illness, or borderline personality disorder. They may have been hospitalized and medicated for these diagnoses but typically have not improved with treatment. At least 75% have made one or more serious suicide attempts, and approximately 33% have mutilated themselves (Putnam et al., 1986). Substance abuse is also quite common (Coons, 1984).

Trust is a major issue for persons with multiple personalities, just as it is for other victims of abuse. Self-protection and secrets are part and parcel of multiple personality disorder. Thus, much of the personal data needed to confirm the diagnosis is not readily available to the therapist early in treatment. The presenting personality may actively withhold information in order to protect the multiple personality system or because important personal material may just not be available to a given personality.

Most reports of clinical experience indicate that fewer than 10% of cases present with abundant evidence of the disorder (Kluft, 1985). Usually, it is only after some time in therapy that a therapist may begin to suspect multiple personality disorder. In addition to the criteria described earlier, Greaves (1980) noted several signs that may suggest the possibility of multiple personality disorder. These signs may appear only gradually and sporadically and can be easily overlooked.

> 1) Time distortion or time lapses, 2) Being told of disremembered behavior, 3) Observers' reports of notable changes, 4) Other personalities elicitable by hypnosis, 5) Use of "we" in a collective versus editorial sense, 6) Discovery of productions (such as writing or art) or objects among one's possession [sic] which neither can be recognized nor accounted for, 7) Severe headaches, 8) The hearing of voices, originating within, but separate, entreating toward good or bad deeds (Kluft, 1984b, p. 23).

Once the possibility of multiple personality disorder or other chronic dissociative disorder is suspected, the clinician should seek out information that will clarify the diagnosis. The therapist will need to explore with the client issues regarding "time loss" or other time distortion. For example, these might include time unaccounted for; behavior that can't be explained, such as purchases made and forgotten; connections with people unknown to the host or presenting personality; and fugue-like experiences wherein the person cannot account for why he or she is in a certain place or how he or she got there.

Such inquiries may begin to elicit in the client a pattern of experiences over his or her lifetime that describes the person's disjointed history. This may include an erratic work history, with abrupt job changes, or equally erratic social and emotional relationships. The person may have been described as "moody" by friends or family and may have been accused of being a liar as a child. The person may evince some knowledge or skill—such as the ability to paint or to write creatively—and not know how he or she acquired it.

Fagan and McMahon (1984, p. 29) summarize the signs of multiple personality disorder or incipient multiple personality disorder in children. Because many of these indicators are seen in other diagnostic groups, the clinician needs to look for a pattern of these signs:

- "In another world." This may be evidence of the person switching back and forth among personalities.
- Responds to or uses more than one name and may seem confused about other names or use the third person to refer to him- or herself.
- Shows marked changes in personality, swinging from one set of characteristics to the opposite (shy to belligerent, demure to seductive, feminine to masculine, etc.).
- Peculiar and perplexing forgetfulness. Confused about basic things such as possessions, teachers' names, and so forth.
- Odd variations in physical skills and attributes: right handed vs. left handed, artistic ability, food preferences.
- Inconsistent schoolwork.
- Disruptive, delinquent, or peculiar behavior.
- Perplexes professionals. They are unable to diagnose the problem or to help child change behavior with usual therapeutic approaches.
- Lies. Denies lying in spite of clear evidence.
- Discipline has little or no effect.
- Discipline responded to by strong protestations of innocence or stoical detachment.
- Delinquent behavior far beyond normal childhood acts.
- Self-injurious, self-mutilating, reckless, takes physical risks.
- Homicidal. Has severely injured other children or adults or attempted assault with a deadly weapon.
- Suicidal—overt, serious attempts.
- Precocious sexuality.
- Truant.
- Lonely. Often ignored, avoided, teased, or rejected by other children.
- Many physical complaints, illnesses, or injuries. These may be hypochondriacal complaints or evidence of physical abuse.
- Hysteric symptoms (sleepwalking, sudden

blindness, epileptic-like seizures, paralysis, loss of sensation).

The child may experience some or all of the following:

- Loses track of time, is disoriented with respect to time and/or place.
- Believes he or she is called by the wrong name.
- Hears voices inside his or her head.
- Feels as if he or she is frequently punished when innocent.
- Has imaginary playmates.
- Is lonely.

Alter Personalities

A person may have two personalities, as was the case in early reports, or as many as several hundred, although many of these do not fit the definition of "personality" and are actually personality fragments. The average number found in several studies was 13 to 15 (Kluft, 1984c; Putnam et al., 1986). One major study (Putnam, 1984) explored the range of characteristics of alter personalities. One third of the therapists surveyed had seen patients change from being right-handed to left-handed and vice versa. One half of the subjects had personalities that responded differently to medication; 75% had personalities with different physical symptoms; 25% had alternate-personality-specific allergies; 75% had personalities claiming to be younger than 12; and 50% had opposite-sex personalities.

Tests were performed with multiple personality disorder patients versus a control group told to "fake" having alter personalities and switching between them (Putnam, 1989b). Tests on both groups included electroencephalograms (EEGs), galvanic skin response tests, and positron emission tomography (PET) scans.

Results indicated that the control group's faking did not sufficiently alter mental and physical results of the tests, whereas the multiple personality disorder group did. The various personalities of the multiple personality disorder patients showed real changes in all the tests as well as during the switching process.

Several types of alter personalities are common in multiple personality disorder. The personality that is most often in control of mind and body is considered the host personality. It is this personality who often presents for treatment and will typically fit the classic presentation described above.

Most people with this disorder have personalities that protect and help the person. Often they serve to protect the individual from persecutor personalities, which are also common in multiple personality disorder patients. The persecuting personality may be self-destructive and may consider him- or herself separate from the host and other personalities.

Sometimes patients have a special helper personality called the *inner-self helper* (Allison, 1974). This personality may be able to provide insight into the workings of the multiple personality system and may also help influence other personalities to cooperate with the therapist. This personality can become a great ally in the treatment process.

Child personalities are very common in multiple personality disorder systems. Some patients may have many child personalities, each of whom retains a tragic memory of the patient's childhood. A lot of the therapeutic work focuses on the child personalities in an effort to gain their trust and to work through long-stored and repressed memories.

Some of the alter personalities may not be aware of other personalities. Other personalities may be aware of all of them but still not know why they exist. Some personalities express the bond of sharing the same body with other personalities, whereas others consider themselves completely independent. Some memories are shared among some of the alter personalities. Other memories are held within an individual personality. The helper personalities often play a nurturing, almost parental role, with one or more of the child personalities. Often, the host does not know about the other personalities.

Treatment

In discussing therapeutic goals with multiple personality disorder patients, Caul stated, "It seems to me that after treatment you want to end up with a functional unit, be it a corporation, a partnership or a one-owner business" (Hale, 1983, p. 106). The treatment goal for most cases of multiple personality disorder is fusion or integration of the personalities into a single unified personality with the concomitant goal of ending the time loss, amnesias, and physiological effects, such as headaches, that these patients experience.

Allison (1974), Bruan (1986), Caul (1978), and Putnam (1989a) have presented guidelines for treatment of this disorder:

1. Establish an atmosphere of safety and trust. This is essential to treatment because the client has been severely victimized in the past.
2. Make the diagnosis and share it with the available personalities.
3. Establish communication with the accessible personalities. This may be done directly or through hypnosis or keeping a journal.
4. Develop a contract with regard to therapy (i.e., limits, avoidance of self-harm, etc.).
5. Gather history on the individual and the system to determine the origin, functions, and problems of each alter personality.
6. Begin to work on the alter personalities' issues.
7. Map the system (i.e., the structure, relationships of the various personalities).
8. Increase communication among the alter personalities. This breaks down the amnesia barriers and the need for separateness is diminished.
9. Work toward recovery and integration of traumatic material.
10. Help patient to develop new coping skills and social supports.
11. Solidify the gains made.
12. Long-term follow-up.

The treatment process is dynamic; most of these steps are overlapping and ongoing. No one right way exists to do therapy with multiple personality disorder patients. Most experts agree that therapeutic effectiveness mainly requires good psychotherapy skills and knowledge about the particulars of the disorder.

The therapist needs to understand the degree of commitment needed for the therapeutic process of treating a multiple personality client. Most therapy lasts a year or longer, and many experts recommend that the client be seen more than once a week. In order to manage this therapy properly, the therapist needs to contract with the client regarding the limits of treatment, the safety of both the therapist and the client, the therapist's privacy, and the safety of the therapist's property. The contract should be negotiated with as many of the alter personalities as possible. Putnam (1989a) recommends a written contract.

Watkins and Watkins (1984) offer several bits of wisdom regarding the therapist–client relationship. In order to build and keep the trust necessary to complete this difficult work, "the patient must perceive the therapist as friendly, strong and unafraid" (p. 116). Eventually, all the alter personalities must believe that the therapist can handle anything that comes up in the treatment process. Moreover, "it is vitally important that the therapist remain on good terms with every ego state" (p. 114). The therapist should keep the following principle in mind:

> The first essential to be recognized by a therapist is that each personality has been created for a purpose to fill a need of the individual, and that one can seldom eliminate it, however malevolent it appears to be, unless the basic need or purpose is met in some more constructive way (p. 113).

This caveat corresponds to Kluft's (1984c) reminder that the therapist should treat all personalities similarly and that "treatment will sink or swim on the quality of the therapeutic alliances developed with the personalities" (p. 14).

The demands on the therapist can be very great, especially when treating his or her first multiple personality client. Because the disorder is relatively rare, most therapists will not have been exposed to extensive literature on the subject. When confronted with his or her first case, the practitioner may attempt to absorb as much knowledge as possible in a short period, which may create a crisis of competence for the therapist. Although it may be difficult to find a supervisor with more experience than the treating therapist, finding someone with experience with such cases can be invaluable. Also, diagnosis of this disorder will be met with skepticism by one's colleagues, resulting in feelings of professional isolation. One's own belief in the diagnosis may also falter from time to time.

These clients may need to be seen two or three times per week. Often, the process of contacting alter personalities and working through the traumatic experiences held in their memories is not easy to fit into a 50- or 60-minute session. The therapist must schedule carefully in order to accommodate other clients and to allow time to process the events of the session. In addition, because journaling is an excellent way for clients to continue therapeutic work outside of the sessions and for alter personalities to "contact" the therapist, the therapist may find him- or herself spending additional time reading the journals of a cooperative client. When added to the time spent keeping notes, talking with colleagues about the case, and just thinking about it, the treatment process can begin to feel quite overwhelming.

The actual experience of being with a multiple personality disorder client—witnessing the switches from one personality to another, often several times in a session, and watching a person relive, from several different perspectives, horribly traumatic episodes of abuse—can be very draining indeed. Being with a person who changes from a tough, swaggering male personality to a cowering, thumbsucking child to a lilting, hopeful "flower child" to a depressed, bland, woeful host personality in a matter of minutes can cause one to question his or her own sense of reality. My experience was echoed by a colleague who described being in an "altered state" during and after sessions with such a client and needing to "come down" and reorient before moving on to another activity. A combination support group and study group of therapists who work with multiple personality disorder clients may help the therapist to cope with these effects.

Therapists should have access to a psychiatrist, who can act as a supervisor or consultant, especially if the psychiatrist has some experience with multiple personality disorder. Although "there is no good evidence that medication of any type has a direct therapeutic effect on the dissociative process as manifested in MPD" (Putnam, 1989a, p. 253), medication may be used to control or ameliorate specific nondissociative symptoms, such as depression, that may interfere with psychotherapy. A psychiatrist can make periodic assessments of the efficacy of medication. Moreover, although outpatient treatment is preferred, the psychiatrist can be a valuable resource if brief hospitalization is necessary.

Case Example

C was 35 years old, married, and the mother of four children. She was participating in a sexual abuse survivors' group as a result of flashbacks of sexual abuse by her mother. In the first group session she revealed graphic details of this abuse but in later sessions seemed unaware of what she had revealed. Her group therapist referred her to me in January 1988 with the goal of uncovering suspected traumatic material through hypnosis.

Prior to being in the survivors' group, C had undergone treatment intermittently since 1978 with at least six different therapists. She had been hospitalized twice for depression and had been treated with antidepressants. During the first session, her presentation fit the typical "host" personality pattern, namely, depressed, blunted affect, anxiety and phobias, and panic attacks. When asked what she wanted out of therapy, she listed work on the above symptoms. However, her first stated goal was to become more "cohesive," in reference to her feeling of being scattered inside.

Several months before I met C, she wrote in her journal,

> I needed to be covered to hide my own self from all that truly scared me because I couldn't face all the fears because there was no way to face them without admitting how badly I was really hurting and if I acknowledged the hurt there would be no way to get through it without admitting all the rest and if I admitted that then I would undo my own self.

She was aware of much but not all the physical abuse she had been subjected to. However, she had no clear memory of sexual abuse, only vague images of "hands" and "eyes." Confusing and conflicting memories and reports are often given by clients with multiple personality disorder.

Despite her stated desire for "cohesiveness," multiple personality disorder was not considered for at least two months in that the author was not familiar enough at that time with the indicators of multiple personality disorder. It wasn't until she had an abreaction after looking at a picture, brought in at my request, of herself at approximately three or four years old that I began to suspect the possibility of multiple personality disorder. At that time, she requested that we work on her fear of bees. I performed a simple hypnotic induction (multiple personality disorder clients are often hypnotized easily) by suggesting she take a deep breath, close her eyes, and "go inside" to find that part of herself that knows more about the bees. Again she had an abreaction, describing a scene in which she had a cage over her head. Her mother wielded an axe, saying she was going to cut C's head off. She also remembered another scene but she couldn't describe it. I asked her to draw it, and she drew a childlike picture of a baby in a crib, a woman with various implements, later discovered to be a shoe horn and a button hook. C was quite disturbed when drawing this but did not recall the scene upon awakening.

In another session, using the same techniques, C described a rape by a stranger when she was 13 years of age as well as mistreatment by her mother and grandmother. She began journaling at my request; multiple personality disorder was further suggested by the widely variant handwriting in her journals.

Upon referral to a psychiatrist, antidepressants were prescribed. As is often the case with such clients, the medications were not effective.

Moreover, the side effects were intolerable so the medication was discontinued.

The diagnosis of multiple personality disorder was made and shared with C. She became quite upset, feeling that she was bad. A week later, a shiver ran through my body as I greeted her in my waiting room. There was something different about her. When we were in my office I said, "You seem different today." When she offered no response, I asked "Who's here?" "I'm Nikki," was the reply. It turned out that Nikki, a male protector personality, had come to "check me out." The session was tense but formed the beginning of an extremely valuable alliance.

I eventually met many other personalities, including five child personalities, three helpers, and a persecutor who later became a helper before finally merging. Other personalities existed whom I didn't meet because they had been "banished" for unacceptable behavior. Each personality served a purpose: one to help untie the ropes that were used to tie her in bed and in the fruit cellar, another to deal with the rape and subsequent sexual experiences, another to "hold onto hope," another to take away the pain, another to deal with the abuse perpetrated by C's father, another to cope with abuses perpetrated by her mother, a "public" personality, the host personality, and others. During the course of therapy, several of these personalities merged, feeling that their issues had been addressed and their work done.

During therapy, boundaries between personalities weaken and blur. Although this is a desired goal, it threatens the system by disallowing customary dissociative means of coping with perceived danger. At this point, the therapeutic alliances and commitment to the goal of wholeness become critical. Not only must a particular personality reexperience the trauma during therapy, but in so doing painful memories "leak" across boundaries into other personalities who had been shielded from the full impact of the abuses. Even the protector personalities begin to experience the pain.

The therapists must let clients know in advance that integration will be a difficult and painful process. Honesty is critical, and the therapist will be challenged throughout the treatment process. The relationship between therapist and client must be a corrective one; that is, it must not be perceived as dishonest and thus repetitive of the client's earlier experience with significant others.

C has often experienced despair during the therapeutic process and has often wished to give up or even die. The alliance established between Nikki and me, begun in that early session, as well as my alliances with other helpers (Tornado and Dreamer) have eased the burden of therapy. In addition, C has continued in the survivors' group, in which she has a warm and meaningful relationship with the group therapist. C has also developed a warm and gentle relationship with the psychiatric consultant. These relationships with loving and trustworthy women have helped her face her fears about women in general and her mother in particular. C's husband has had limited involvement in therapy sessions, per his wish. However, he has been very understanding of and supportive to C throughout this painful process. C's children have not yet been told about C's diagnosis but they are becoming involved in family sessions.

C is a bright and talented woman who has been an underachiever throughout much of her life. Her current goal is to return to college in order to discover what she is capable of doing. Her work is far from done, but everyone involved in the therapeutic process is optimistic that she will eventually free herself from this disorder and be able to build on the strengths she has developed.

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Psychopharmacology and the Major Psychiatric Disorders

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by C. Lindsay DeVane, Pharm.D., F.C.C.P.
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Table 1F.5.
Classification of Psychotic Disorders

- I. Schizophrenia
  - A. Disorganized
  - B. Catatonic
  - C. Paranoid
  - D. Undifferentiated
  - E. Residual
- II. Schizophreniform disorder
- III. Brief reactive psychosis
- IV. Schizoaffective disorder
  - A. Bipolar type
  - B. Depressive type
- V. Induced psychotic disorder
- VI. Delusional (paranoid) disorder

Table 1F.6.
Target Symptoms for Monitoring Response to Antipsychotic Therapy

Positive Symptoms	Negative Symptoms
Delusions	Poor social skills
Hallucinations	Impaired judgment
Bizarre behavior	Inability to prioritize tasks
Grandiosity	Inability to initiate conversation
Paranoid ideation	Loss of punctuality

A

Chlorpromazine Database

FORMULATIONS

Chlorpromazine hydrochloride tablets: 10 mg, 25 mg, 50 mg, 100 mg, 200 mg
Chlorpromazine hydrochloride capsules: 30 mg, 75 mg, 150 mg, 200 mg, 300 mg
Chlorpromazine hydrochloride syrup: 10 mg/5 ml; concentrate, 30 mg/5 ml
Chlorpromazine suppositories: 25 mg, 100 mg
Chlorpromazine hydrochloride injection: 25 mg/ml
Brand names: Thorazine (SKF); Prompar (Parke-Davis); various generic brands

Table 3A.2.
Expected Physiological Effects from Chlorpromazine Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Frequent slight tachycardia
ECG	Prolongation of Q-T interval, S-T segment depression
Blood pressure	Orthostatic hypotension is common; fall in blood pressure
Respiratory function	Slight decrease in respiratory rate
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults; occasional apparent diuretic actions
Hepatic function	
SGOT, SGPT, alkaline phosphatase	Transient benign increases may occur during first month. Substantial increases accompanied by increases in bilirubin should prompt further assessment of liver function. Occasional hypersensitivity reaction and obstructive jaundice occurs, usually in 2nd to 4th week of therapy with high levels of alkaline phosphatase and bilirubin.
Triglyceride, cholesterol	Serum concentrations have been reported to show no changes or transient rises after initiation of therapy. High density lipoprotein cholesterol may decrease.
Hematology status	
CBC	Leukocytosis, leukopenia, and eosinophilia may occur. Agranulocytosis and thrombocytopenia are rare.
Neuroendocrine status	
Glucose tolerance	Acute doses may cause hyperglycemia and inhibit insulin secretion; little effect is due to chronic low doses.
Serum prolactin	Elevated in men and women throughout therapy; no tolerance develops.
Other tests	
Serum magnesium, serum calcium	Slight decreases during therapy have been noted with other phenothiazines.

[a] Abbreviations: BUN, blood urea nitrogen; SGOT, serum glutamic-oxaloacetic transaminase; SGPT, serum glutamic-pyruvic transaminase; CBC, complete blood count.

Table 3A.3.
Pharmacokinetic Parameters of Chlorpromazine

Parameter	Range
Bioavailability	Nearly complete absorption; total bioavailability reduced from extensive presystemic elimination
Time of peak concentration after single dose	Between 30 minutes and 4 hours
Plasma protein binding	90% or above
Volume of distribution	10 to 35 liters/kg (mean of 20)
Total plasma clearance	IM: mean of 0.6 liter/min Oral: approaches or exceeds hepatic blood flow (1.5 liters/min)
Renal clearance	Negligible
Elimination half-life	Range of 6 to 118 hours; mean of 30
Active metabolites	7-Hydroxychlorpromazine
Therapeutic range	30 to 350 ng/ml for antipsychotic effects; greater than 750 ng/ml associated with frequent adverse effects.

INDICATIONS

Given its diverse pharmacologic effects (Table 3A.1), chlorpromazine has many potential uses. The Food and Drug Administration (FDA)-approved uses in psychiatry include the management of psychotic disorders and of the manic state of bipolar affective disorders and the short-term treatment of severe agitation, hyperactivity, or aggressiveness in disturbed children. Nonpsychiatric uses include relief of intractable hiccups, acute intermittent porphyria, hyperthermia, and restlessness and apprehension before surgery and control of nausea and vomiting. Table 3A.4 is a list of disorders for which chlorpromazine has been tried.

The treatment of psychotic behavior is the primary indication for chlorpromazine. Numerous controlled trials have indicated its utility in reducing the delusions, hallucinations, and bizarre behavior that accompanies schizophrenia. Psychotic behavior may be manifested in a number of treatable psychiatric disorders (Table 3A.4).

Table 3A.4.
Conditions for Which Chlorpromazine May Have Beneficial Effects

Psychotic disorders, including acute and chronic schizophrenia
Organically induced psychoses (PCP, amphetamine abuse)
Nausea and vomiting
Intermittent porphyria
Intractable hiccups
Tetanus
Surgical restlessness/apprehension
Antihypertensive after open-heart surgery
Schizoaffective disorder
Premenstrual psychotic or dysphoric symptoms

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

The precautions to be considered when using chlorpromazine are numerous as adverse effects can involve most organ systems. Chlorpromazine should not be administered to patients who are comatose or in the presence of large amounts of central nervous system (CNS) depressants (alcohol, barbiturates). Chlorpromazine may impair cognitive ability, and patients may find some usual daily activities, such as safely driving an automobile, to be compromised.

Chlorpromazine can impair body temperature regulation through its actions in the hypothalamus and by suppression of sweating. The extreme result of this effect has been fatal hyperpyrexia. The possibility of heat stroke can be reduced by avoiding combination therapy with other anticholinergic drugs and excessive outdoor activities associated with high temperatures and humidity. Patients who swim may occasionally complain of chills after body exposure in cold water.

Table 3A.5.
Drug Interactions with Chlorpromazine

Interacting Drug	Effect
Aluminum salts; antacids	Aluminum-based antacids, kaolin, attapulgite may decrease the absorption of chlorpromazine.
Barbiturates	Hepatic enzyme induction results in decreased chlorpromazine plasma concentrations; additive CNS depression can occur.
Methadone, alcohol	Additive CNS depression can occur.
Propranolol	Pharmacological effects of both drugs may be increased through alterations in the drugs' first-pass metabolism in the liver.
Epinephrine	Hypotension and tachycardia can result. The α-receptor blocking effects of chlorpromazine leave the β-adrenergic agonist activity of epinephrine unopposed.
Guanethidine	Inhibition of neuronal uptake by chlorpromazine may decrease antihypertensive effectiveness.
Cimetidine	Uncertain: the absorption of chlorpromazine may be delayed and the metabolites inhibited, producing variability in plasma concentrations.
Anticholinergics	Additive anticholinergic effects; an unsubstantiated decrease in chlorpromazine effectiveness
Cyclic antidepressants	A mutual metabolic inhibition can raise plasma concentrations of either drug or both; additive anticholinergic effects.

Table 3A.6.
Expected Side Effects of Chlorpromazine Therapy

Effect	Rare	Less Common	More Common
Dry mouth			X
Blurred vision		X	
Constipation			X
Nausea		X	
Vomiting		X	
Drowsiness			X
Dizziness			X
Ataxia		X	
Fainting		X	
Disorientation		X	
Headache		X	
Muscle spasms			X
Restlessness			X
Shuffling walk			X
Tic-like movements of head, face		X	
Difficult urination			X
Skin rash		X	
Blood pressure decrease			X
Tachycardia			X
Jaundice	X		
Breast swelling	X		
Gynecomastia (males)		X	

B

Haloperidol Database

FORMULATIONS

Haloperidol tablets: 0.5 mg, 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Haloperidol concentrate: 2 mg/ml
Haloperidol injection: 5 mg/ml
Haloperidol decanoate injection: 50 mg/ml
Brand names: Haldol (McNeil); various generic brands

INDICATIONS

Haloperidol is a broadly useful drug in psychiatry. The FDA-approved indications are for use in management of the manifestations of psychotic disorders, for the control of tics and vocal utterances of Tourette's disorder in children and adults, and for the treatment of severe behavioral problems in children. Haloperidol is effective in the short-term treatment of hyperactive children who show excessive motor activity with accompanying conduct disorder. Unapproved uses of haloperidol include prevention and treatment of emesis due to various causes, including cancer chemotherapy, irradiation, and gastrointestinal disorders and in postoperative patients (7). Haloperidol has shown promising effectiveness in the treatment of stuttering and in the treatment of autism in children (8).

Table 3B.1.
Expected Physiological Effects from Haloperidol Therapy for Monitoring[a]

Parameter	Drug Effect and Time Course
Cardiovascular status	
Heart rate	Slight increase
ECG	Similar changes as with chlorpromazine; ST segment depression
Blood pressure	Slight decrease, occasional orthostatic response
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults.
Hepatic function	
SGOT, SGPT, alkaline phosphatase	Transient benign increases may occur during 1st month. Substantial increases accompanied by increases in bilirubin should prompt further assessment of liver function.
Hematology status	
CBC	Mild and transient leukopenia or leukocytosis; minimal decrease in erythrocyte count. Thrombocytopenia occurs less often than with phenothiazines.
Neuroendocrine status	
Prolactin	Elevated concentrations throughout therapy

[a] For abbreviations, see Table 3A.2, footnote *a*.

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Haloperidol is contraindicated in severe CNS depression, in comatose states from any cause, and in individuals who have Parkinson's disease or who are hypersensitive to the drug. It may impair mental and/or physical abilities required for operating machinery or driving a car. The ambulatory patient should be warned accordingly. Alcohol should not be used with haloperidol because of the additive impairment of mental or physical functioning and the possibility of contributing to hypotension.

Although haloperidol has a relatively mild hypotensive effect, patients with severe cardiovascular disorders may experience transient hypotension and/or precipitation of anginal pain. If a vasopressor is required, norepinephrine or dopamine rather than epinephrine should be used as the latter leads to unopposed β-receptor stimulation and will possibly induce further hypotension.

Haloperidol may lower the seizure threshold, so anticonvulsant therapy should be monitored closely in patients with seizure disorders. When using antipsychotic drugs in patients with a seizure history, gradual dosage adjustment is recommended to avoid seizures.

Table 3B.3.
Drug Interactions with Haloperidol

Interacting Drug	Effect
Lithium	Questions about enhanced neurotoxicity have not been fully resolved. Use of the combination should be closely monitored for neurological toxicity.
Phenytoin, barbiturates, carbamazepine, smoking	Hepatic enzyme induction results in decreased plasma concentrations.
Guanethidine	Due to inhibition of neuronal uptake of guanethidine by haloperidol, the antihypertensive effectiveness may be reduced.
Tricyclic antidepressants	A mutual metabolic inhibition may raise plasma concentrations of either drug. The pharmacodynamic consequences remain to be fully defined.

Table 3B.4.
Expected Side Effects from Haloperidol Therapy

Effect	Rare	Less Common	More Common
Dry mouth		X	
Blurred vision	X		
Constipation		X	
Nausea		X	
Vomiting		X	
Drowsiness		X	
Dizziness		X	
Ataxia		X	
Fainting		X	
Disorientation		X	
Headache		X	
Muscle spasms			X
Restlessness			X
Shuffling walk			X
Tic-like movements of head, face			X
Difficult urination	X		
Skin rash	X		
Blood pressure decrease		X	
Tachycardia		X	
Jaundice	X		
Gynecomastia (males)		X	

Clozapine Database

FORMULATIONS

Clozapine tablets: 25 and 100 mg
Brand names: Clozaril; Leponex (Sandoz)

Table 3C.2.
Expected Physiological Effects from Clozapine Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Sinus tachycardia, up to 120 beats/minute
ECG	Occasional flattening of T-wave, shortening of P-Q interval
Blood pressure	Orthostatic hypotension can occur, sometimes severe.
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults. Occasional apparent diuretic actions.
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Transient increases may occur during first few weeks of therapy unaccompanied by physical symptoms. Increases in bilirubin should prompt further assessment of liver function.
Hematology status	
CBC	Leukocytosis, leukopenia, and eosinophilia may occur. Reversible granulocytopenia can occur. CBC is recommended weekly for the duration of therapy. If WBC is below 3500, then it should be rechecked bi-weekly. WBC below 3000 or granulocyte count below 1500 is an indication for discontinuing therapy.
Neuroendocrine status	
Body temperature	Hyperthermia is common in 10% or more of patients, but is usually mild and self-limited.

[a] Abbreviations: BUN, blood urea nitrogen; AST, aspartate aminotransferase; SGOT, serum glutamic-oxaloacetic transaminase; ALT, alanine aminotransferase; SGPT, serum glutamic-pyruvic transaminase; WBC, white blood cell count.

INDICATIONS

Clozapine is indicated for use in the management of acute and chronic psychotic disorders in three types of patients. The first group is those patients who are refractory to treatment with conventional neuroleptics. In clinical trials these patients have shown inadequate clinical response to at least two different antipsychotic drugs and have been treated for an adequate duration of time.

Table 3C.3.
Pharmacokinetic Parameters of Clozapine

Parameter	Range
Bioavailability	Nearly complete absorption; total bioavailability reduced to approximately 70% from presystemic elimination
Time of peak concentration after single dose	Between 1 and 4 hours
Plasma protein binding	90% or above
Volume of distribution	1 to 10 liters/kg (mean of 4.6)
Total plasma clearance	Oral: 11 to 105 liters/hr (mean of 45 liters/hr)
Renal clearance	Negligible
Elimination half-life	Range of 6 to 33 hours; mean of 16
Active metabolites	Uncertain; demethylated metabolites could have some activity.
Therapeutic range	Not established; no correlation has been found in limited studies between plasma concentration and either efficacy or adverse effects. Usual doses produce plasma concentrations with a range of 100 to 600 ng/ml.

Many of these patients will have a history of multiple hospital admissions. Typically, florid psychotic symptoms are present despite doses of antipsychotics at the upper range of recommended doses. In controlled trials, clozapine proved superior to chlorpromazine for this type of patient (2–4). Many patients had also shown unsatisfactory response to haloperidol. During the largest multicenter trial (2), clozapine proved superior to chlorpromazine for improving positive symptoms of schizophrenia during the entire 6-week active treatment period and proved superior for treatment of negative symptoms from weeks 2 to 6.

A second group of patients are those who cannot receive adequate doses of typical antipsychotics to control their symptoms because of intolerable extrapyramidal side effects. As discussed later (see Chapter 3E) some patients do not respond to antiparkinson drugs and are difficult to treat. The low incidence of extrapyramidal symptoms with clozapine makes it an apppropriate choice in many of these patients.

Finally, a third group of schizophrenic patients with tardive dyskinesia must continue to be treated because of psychotic symptoms, yet are drug-intolerant. These patients either develop a worsening of dyskinetic movements with continued antipsychotic treatment or are dysfunctional because of their tardive dyskinesia. Some patients' symptoms of tardive dyskinesia were suppressed during treatment with clozapine. However, low doses, less than 250 mg/day, do not seem effective. Guidelines for treating these patients are needed from further clinical research.

Clozapine has been tried as a treatment for abnormal involuntary movement disorders (13, 14). The results have been equivocal. Two patients with Huntington's disease showed a marked decrease in movements, but other patients with Tourette's syndrome showed no improvement. Some patients with tardive dyskinesia had a suppression of their symptoms of tardive dyskinesia while taking

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Agranulocytosis has occurred in patients receiving clozapine (see "Adverse Reactions," below). This drug reaction, reversible upon early detection, is apparently an unpredictable, possibly immunological phenomenon unrelated to dosage. The risk is as high as 1 to 2% of patients treated for a year. Fatalities have occurred but only in patients identified after the onset of symptoms of infection (1). This risk must be balanced against the very poor prognosis for some chronic refractory schizophrenics. State hospitals contain many psychotic patients whose quality of life is dismal and whose prospects for useful interactions with society are limited to custodial care.

The incidence of bone marrow suppression with clozapine is no greater than exists with many chemotherapeutic agents and some other widely prescribed drugs (16). For example, estimates of the frequency of neutropenia associated with sustained-release procainamide is 0.55 to 4.4% (17). However, clozapine's estimated incidence of bone marrow suppression is higher than that of other antipsychotic agents.

Routine frequent monitoring of blood cell counts is the best possible approach to detection of drug-induced hematological abnormalities. However, this is not a fail-safe practice as occasionally granulocytopenia can occur rapidly. Attention should be paid to any symptoms that suggest infection, and appropriate investigation and treatment should be initiated when indicated. Patient fatalities from agranulocytosis usually result from secondary infections.

Clozapine should not be used in combination with other drugs known to depress bone marrow function, including other antipsychotics, or in patients with a history of myeloproliferative disorders.

Unless toxicity requires rapid discontinuation of clozapine, it should be withdrawn gradually. Two patients developed pronounced psychotic symptoms within 48 hours when clozapine was abruptly discontinued (18). Ordinarily, patients do not relapse for 2 weeks or longer after discontinuing antipsychotic therapy, although many patients will relapse within 6 months. These two cases of rapid clinical deterioration suggest that a clozapine-induced supersensitivity psychosis may have occurred.

Like most antipsychotics, clozapine can lower the seizure threshold. Seizures have been reported with clozapine. At doses of 600 mg/day and higher, the risk seems to be greater than with other antipsychotics (11). Generally, there seems to be a relationship between the dose of antipsychotic given and the incidence of seizures. This suggests that patients with a history of seizure disorder should be given the lowest possible dose of all antipsychotics. Anticonvulsant medication should be continued in patients receiving clozapine, but attention should be paid to the possibility that adding clozapine to an existing anticonvulsant regimen may result in a drug interaction. Plasma concentrations of anticonvulsants should be monitored if toxicity is suggested or seizure frequency increases.

Table 3C.4.
Predicted Drug Interactions with Clozapine

Interacting Drug	Effect
Alcohol, barbiturates, benzodiazepines	Enhanced sedative effects
Epinephrine	Hypotension and tachycardia can result. The α-receptor blocking effects of clozapine leave the β-adrenergic agonist activity of epinephrine unopposed.
Anticholinergics	Additive anticholinergic effects; delirium could occur.
Cyclic antidepressants	Have been successfully coadministered, but highly anticholinergic drugs could lead to delirium.
Enzyme inhibitors (cimetidine, disulfiram, isoniazid)	Could interfere with the metabolism and elimination of clozapine
Enzyme inducers (rifampin, cigarette smoking)	Could hasten the elimination of clozapine and lower its steady-state concentrations

Table 3C.5.
Expected Side Effects of Clozapine Therapy

Effect	Rare	Less Common	More Common
Hypersalivation			X
Drowsiness, sedation			X
Nasal stuffiness			X
Blood pressure decrease			X
Tachycardia			X
Hyperthermia			X
Bone marrow suppression		X	
Leukopenia		X	
Dry mouth		X	
Blurred vision		X	
Constipation		X	
Nausea		X	
Vomiting		X	
Headache		X	
Akathisia		X	
Tremor		X	
Rigidity		X	
Skin rash		X	
Weight gain		X	
Jaundice	X		
Difficult urination	X		

D

Intraclass Comparisons of Antipsychotics

Table 3D.1.
Classification of Antipsychotics and Usual Daily Doses

Chemical Class & Generic Name	Approximate Equivalent Dose (mg)	Usual Daily Dose Range (mg/day)	
		Outpatient	Inpatient
PHENOTHIAZINES:			
Aliphatic			
Chlorpromazine	100	50–400	200–1600
Piperidine			
Thioridazine	100	50–400	200–800
Mesoridazine	50	25–200	100–400
Piperazine			
Perphenazine	10	8–24	12–64
Butaperazine	10	10–30	10–100
Trifluoperazine	5	4–10	10–60
Fluphenazine	2–3	1–5	2–60
THIOXANTHENE:			
Thiothixene	5	6–30	10–120
DIBENZOXAZEPINE:			
Loxapine	10	15–40	40–160
INDOLE:			
Molindone	10	15–60	40–225
BUTYROPHENONE:			
Haloperidol	2–3	2–6	4–100
DIBENZAZEPINE:			
Clozapine	50	50–400	50–800

Table 3D.2.
Pharmacological Comparison and Relative Side Effect Profile of Some Prominent Antipsychotics

Drug or Drug Class	Sedation Potential	Muscarinic Blockade	Orthostatic Hypotension	EPS Potential
Phenothiazines:				
Aliphatic	strong	moderate	strong	moderate
Piperidine	moderate	strong	moderate	moderate
Piperazine	weak	weak	weak	strong
Thiothixene	strong	moderate	strong	moderate
Loxapine	moderate	moderate	moderate	moderate
Haloperidol	weak	weak	weak	strong
Molindone	weak	weak	weak	moderate
Clozapine	strong	strong	moderate	weak

Table 3D.3.
Pharmacokinetic Parameters of Antipsychotics

Drug	Oral Availability	Volume of Distribution (liters/kg)	Elimination Half-life (hours)	Active Metabolites
Chlorpromazine	0.25–0.75	10–35	mean of 30	7-hydroxy
Clozapine	0.9	2.2–10	6 to 33	
Haloperidol	0.25–0.75	13–25	mean of 18	reduced haloperidol
Thioridazine	0.4–0.9	10–20	9-10	mesoridazine

SURVIVING SCHIZOPHRENIA: A Family Manual
Torrey, E.F. (1983) p. 113.

Table 1

Types of Antipsychotic Drugs

Type	Generic Name	Trade (Brand) Names*
Aliphatic phenothiazines	chlorpromazine	Thorazine, Chloramead, Chlorprom, Chlor-Promanyl, Largactil, Promachlor, Promapar, Promosol, Terpium, Sonazine
	promazine	Sparine, Norzine, Promabec, Promanyl
	triflupromazine	Vesprin
Piperidine phenothiazines	thioridazine	Mellaril, Novoridazine, Thioril
	mesoridazine	Serentil
	piperacetazine	Quide
Piperazine phenothiazines	fluphenazine	Prolixin, Permitil, Moditen
	trifluoperazine	Stelazine, Clinazine, Novoflurazine, Pentazine, Solazine, Terfluzine, Triflurin, Tripazine
	perphenazine	Trilafon, Phenazine
	prochlorperazine	Compazine, Stemetil
	carphenazine	Proketazine
	acetophenazine	Tindal
	thiopropazate	Dartalan
	butaperazine	Repoise
Thioxanthines	thiothixene	Navane
	chlorprothixene	Taractan
Butyrophenones	haloperidol	Haldol
	droperidol	Inapsine
Dibenzepines	loxipine	Loxitane, Daxolin
Dihydroindolones	molidone	Moban, Lindone

*The trade names of drugs can be found in the *American Drug Index* (Philadelphia: Lippincott, 1981) and the *U.S. Pharmacopeia Dispensing Information* (Rockville, Md.: U.S. Pharmacopeia, 1981).

SURVIVING SCHIZOPHRENIA: A Family Manual
Torrey, E.F. (1983) p. 117.

Table 2

Equivalent Doses of Antipsychotic Drugs

The following list of antipsychotic drugs by drug equivalency is only approximate. Fluphenazine and haloperidol, the most potent (and among the most used) are taken as the baseline. To find out what an equivalent dose of another drug is, multiply by the number indicated. Thus 10 milligrams of fluphenazine is approximately equivalent to 20 milligrams of thiothixene (× 2), 50 milligrams of molindone (× 5), 100 milligrams of acetophenazine (× 10), 150 milligrams of mesoridazine (× 15), and 200 milligrams of chlorpromazine (× 20).

Generic Name	Trade (Brand) Names
Baseline	
fluphenazine	Prolixin, Permitil, Moditen
haloperidol	Haldol
droperidol	Inapsine
Multiply × 2	
thiothixene	Navane
trifluoperazine	Stelazine and others
Multiply × 5	
perphenazine	Trilafon, Phenazine
butaperazine	Repoise
molindone	Moban, Lidone
loxapine	Loxitane, Daxolin
thiopropazate	Dartalan
piperacetazine	Quide
Multiply × 10	
prochlorperazine	Compazine, Stemetil
carphenazine	Proketazine
triflupromazine	Vesprin
acetophenazine	Tindal
Multiply × 15	
mesoridazine	Serentil
chlorprothixene	Taractan
Multiply × 20	
thioridazine	Mellaril, Novoridazine, Thiori
chlorpromazine	Thorazine and others

NOTE: Adapted from R. I. Shader, ed., *Manual of Psychiatric Therapeutics* (Boston: Little Brown & Co., 1975); J. M. Davis, "Comparative Doses and Costs of Antipsychotic Medication," *Archives of General Psychiatry* 33 (1976): 858–61; and R. J. Baldessarini, "The Neuroleptic Antipsychotic Drugs," *Postgraduate Medicine* 65 (1979): 108–19. Differences among the authors were averaged.

E

Benztropine Database

FORMULATIONS

Benztropine mesylate tablets: 0.5 mg, 1.0 mg, 2.0 mg
Benztropine mesylate injection: 1 mg/ml in 2-ml ampules
Brand name: Cogentin (Merck)

INDICATIONS

Benztropine is used as an adjunct in the therapy of all forms of Parkinson's disease. It is also used in the control of extrapyramidal side effects caused by antipsychotic drugs (5). It is not used for the treatment of tardive dyskinesia.

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Benztropine is contraindicated in children under 3 years of age. It should only be used cautiously in older children. Hypersensitivity to benztropine is a rare contraindication.

Benztropine may decrease sweating because of its similarity to atropine. Therefore, it should be administered cautiously during hot weather, especially when given with other anticholinergic drugs to the chronically ill, those with central nervous system disease, and those who do manual labor in a hot environment. Hyperthermia is a possible consequence of anhidrosis, and fatalities have occurred.

Benztropine should not be used in people with glaucoma, particularly angle-closure glaucoma; pyloric or duodenal obstruction; stenosing peptic ulcers; prostatic hypertrophy or bladder neck obstructions; or mysasthenia gravis. Patients taking benztropine who report gastrointestinal complaints should be promptly questioned about the cause and further investigation started, if necessary. Paralytic ileus, sometimes fatal, has been reported in patients taking anticholinergic-type antiparkinson drugs in combination with phenothiazines and/or tricyclic antidepressants.

The subjective effects of antiparkinsonian medications have been perceived as pleasurable by some individuals. This has led to benztropine and similar drugs becoming substances of abuse (9, 10). Trihexylphenidate (see Chapter 3F) seems to be the preferred drug. Single doses of only 2 to 4 times the usual daily dose may produce the disorientation and visual hallucinations typical of anticholinergic delirium. However, a steep dose-response curve (see Chapter 1C) between mild euphoria and toxicity has prevented widespread popularity of this form of substance abuse. Clinicians should take a careful drug history to uncover antiparkinsonian drug abuse. It may be difficult to distinguish between psychopathology and the behavioral effects from mild intoxication.

F

Intraclass Comparisons of Antiparkinson Drugs

Parkinson's disease is a neurological disorder characterized by tremor, rigidity, akinesia, and difficulties in maintaining posture and equilibrium. Several causes are recognized. The pathophysiological basis is complex but partly involves a deficiency of dopamine in the basal ganglia area of the brain (Chapter 1B). This results in an imbalance between acetylcholine and dopamine. Some of the drugs that are effective in reversing the symptoms of parkinsonism either increase neurotransmission by acting as dopamine agonists (L-DOPA, amantadine, bromocriptine) or decrease cholinergic neurotransmission by acting as muscarinic antagonists.

Symptoms of parkinsonism may be drug-induced. All of the effective antipsychotic drugs, with the possible exception of clozapine, can produce pseudoparkinsonism and other neurological side effects (1–3). These are collectively known as extrapyramidal symptoms (EPS). The most common are dystonias and akathisia. A comparison is shown in Table 3F.1. The presence of these side effects can seriously undermine the therapeutic goals of antipsychotic drug therapy, prolong hospitalization, and contribute to the patient's inactivity. Some dystonias (e.g., oculogyric crises) can present as serious medical conditions. Akathisia can be distressing and result in maladaptive reactions, even contributing to suicidal behavior. The anticholinergic drugs can reverse or prevent most antipsychotic-induced EPS. L-DOPA,the immediate precursor of dopamine, has not been systematically studiedfor the treatment of antipsychotic-induced EPS.

Table 3F.1.
Neurological Side Effects of Antipsychotic Drugs

Reaction	Features	Usual Time of Appearance during Therapy	Treatment
Acute dystonia	Spasm of muscles of tongue, face, neck	1 to 5 days	Antiparkinson agents (IM or IV, then oral)
Pseudoparkinsonism	Bradykinesia, rigidity, variable tremor, mask facies, shuffling gait	5 to 30 days	Antiparkinson agents (oral)
Akathisia	Motor restlessness	5 to 60 days	Reduce dose or change drug; antiparkinson drugs usually help
Tardive akathisia	Motor restlessness	weeks after withdrawal of antipsychotic	Antiparkinson agents (oral)
Tardive dyskinesia	Oral-facial dyskinesia; choreoathetosis	months to years	No adequate therapy; antiparkinson drugs are not recommended

Table 3F.2.
Usual Dosages of Antiparkinson Drugs for EPS

Drug	Brand Name	Dose Range (mg/day)	Equivalent Dose (mg)
Benztropine	Cogentin	0.5–8	2
Trihexyphenidyl	Artane	2–20	5
Procyclidine	Kemadrin	5–20	5
Biperiden	Akineton	4–8	4
Diphenhydramine	Benadryl	25–200	50
Amantadine	Symmetrel	100–300	100

Table 3F.3.
Medical and Psychiatric Manifestations of Anticholinergic Toxicity

Peripheral
  Tachycardia
  Dry mucous membranes
  Urinary retention
  Blurred vision
  Constipation
Central
  Delirium
  Disorientation
  Ataxia
  Reduced ability to concentrate
  Euphoria
  Seizures in severe cases
  Confusion
  Recent memory difficulties
  Hallucinations, visual or auditory
  Delusions
  Irritability
Predisposing factors
  High (greater than 450 ng/ml) plasma concentrations of tricyclics
  Polypharmacy (two or more drugs with anticholinergic properties)
  Advanced age
  Concurrent CNS disease

Table 1F.1.
Major Mental Disorders and Pharmacotherapy

Major Disorder	Examples: Drugs Used Routinely or Experimentally in Treatment for Either Primary or Associated Symptoms
Disorders evident in infancy, childhood, or adolescence	Mental retardation, conduct disorder, anorexia nervosa, attention-deficit disorder, bulimia nervosa CA, STIM, LI[a], MAOI[b]
Organic mental disorders	Alzheimer's disease, multi-infarct dementia A-PSYCH, BENZO, HYP
Substance use disorders	Alcohol dependence, cocaine dependence, opioid dependence CA, LI, BENZO, clonidine, disulfiram, methadone, propranolol
Psychotic disorders	Brief reactive psychosis, schizoaffective disorder, schizophrenia A-PSYCH, CA, LI, HYP[a], BENZO[a]
Mood disorders	Bipolar disorder (manic), major depression CA, STIM, BENZO, HYP, MAOI, A-CONVUL
Anxiety disorders	Panic disorder, agoraphobia, posttraumatic stress disorder BENZO, HYP, CA, MAOI, A-CONVUL[a]
Dissociative disorders	Multiple personality disorder, psychogenic fugue
Disorders of impulse control	Pathological gambling, intermittent explosive disorder LI, A-CONVUL
Personality disorders	Antisocial, borderline, narcissistic, schizotypal LI, BENZO, A-PSYCH

[a] Drug used experimentally.
[b] CA, cyclic antidepressants; STIM, stimulants; A-PSYCH, antipsychotics; BENZO, benzodiazepines; LI, lithium; A-CONVUL, anticonvulsants used as mood stablizers; HYP, hypnotics; MAOI, monoamine oxidase inhibitors.

Table 1F.2.
Classification of Mood Disorders

I. Major depression
    A. Single episode
    B. Recurrent
II. Dysthymia
III. Bipolar disorder
    A. Mixed
    B. Manic
    C. Depressed
IV. Cyclothymia

Table 1F.3.
Target Symptoms for Monitoring Response to Antidepressant Therapy

Cognitive Symptoms	Physical Symptoms
Dejected mood	Loss or increase of appetite
Self-blame	Psychomotor agitation or retardation
Low self-esteem	Sleep disturbance
Self-depreciation	Loss of libido
Loss of gratification	Gastrointestinal upset
Loss of attachments	Diurnal fluctuation of mood
Loss of sense of humor	
Negative expectations	
Increasing ambivalence	
Delusions	
Increasing dependence	
Hallucinations	
Suicidal ideation	
Loss of motivation	

Table 1F.4.
Target Symptoms for Monitoring Response to Antimanic Therapy

Affective Symptoms	Psychomotor Symptoms	Cognitive Symptoms
Irritability	Sleep disturbance	Delusions (e.g., sexual prowess, persecutory, religious, grandiosity)
Labile mood	Pressured speech	Racing thoughts
Short attention span	Talkative	Ideas of reference
Euphoria	Flight of ideas	Hallucinations
Manipulative behavior	Assaultive behavior	Flight of ideas
Elevated or expansive mood	Increased activity	

A

Lithium Database

FORMULATIONS

Lithium carbonate tablets: 300 mg (8.12 mEq of lithium)
Lithium carbonate capsules: 300 mg (8.12 mEq of lithium)
Lithium carbonate tablets, sustained release: 300 mg (8.12 mEq of lithium); 450 mg (12.18 mEq of lithium)
Lithium citrate syrup: 8 mEq of lithium per 5 ml
Brand names: Lithium carbonate (Roxane); Eskalith (SKF); Lithonate (Rowell); Lithane (Miles Pharmaceuticals); Lithotabs (Rowell); Lithobid (Ciba)

Table 2A.1.
Expected Physiological Effects from Lithium Therapy[a] for Monitoring

Parameter	Drug Effect
Thyroid function	
T-4, T-3	Decreases noted within 4 mo with reversal to pretreatment levels within 12 mo of continuous therapy
TSH	Persistent increases noted within 4 mo of beginning therapy
Cardiovascular status	
ECG	Depression of T-waves at upper end of therapeutic concentrations; rarely, inversion
Heart rate, blood pressure	No changes expected in healthy patients
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults over several years; children have been followed for 3 to 5 yr without changes; values will deteriorate markedly in toxic states.
Urine output	Frequent increases above 2 liters/24 hr correlating with duration of therapy; may begin soon after beginning therapy and frequently, but not always, parallels polydipsia.
Hepatic function	
AST (SGOT), ALT (SGPT)	No effect expected on hepatic enzymes
Hematology status	
CBC	Significant but innocuous leukocytosis within 1 to 3 wk, reversible within 1 wk off of lithium
Neuroendocrine status	
Dexamethasone suppression test	No effects expected
Fasting blood glucose	Short-term (1 yr) decrease, but no chronic effects expected; increases should prompt further patient assessment.

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[a] Abbreviations: T-4, serum thyroxine; T-3, serum triiodothyronine; TSH, thyroid-stimulating hormone; ECG, electrocardiogram; BUN, blood urea nitrogen; AST, asparate aminotransferase; SGOT, serum glutamic oxaloacetic transaminase; ALT, alanine aminotransferase; SGPT, serum glutamic pyruvic transaminase; CBC, complete blood count.

INDICATIONS

Lithium is approved by the Food and Drug Administration (FDA) for treatment of acute mania and for prophylaxis of bipolar affective disorder. Numerous, well-controlled studies have shown that lithium induces improvement or remission in greater than 70% of patients with acute mania. Placebo-controlled trials have also shown that it is effective in manic-depressive patients in preventing both manic and depressive episodes (6, 7). Lithium has also been tried in a variety of other psychiatric disorders, with varying degrees of success.

Table 2A.2.
Pharmacokinetic Parameters of Lithium

Parameter	Range
Peak concentration from a single 600-mg dose of lithium carbonate	0.45 to 0.85 mEq/liter
Time of peak concentration	0.5 to 2 hr for rapid release tablets; 4 to 12 for delayed release
Total body clearance	Equal to renal clearance
Renal clearance	10 to 40 ml/min
Hepatic clearance	None
Elimination half-life	18 to 24 hr in young adults; 30 to 36 hr in elderly
Plasma protein binding	None
Volume of distribution	0.8 to 1.2 liter/kg
Therapeutic range:	
Antimanic	0.8 to 1.4 mEq/liter
Prophylaxis	0.4 to 1.0 mEq/liter

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

The use of lithium should not be undertaken lightly. As stated previously, lithium toxicity is closely related to serum levels and can occur at therapeutic doses. Facilities for serum lithium determinations are required to monitor therapy. The risk/benefit considerations in preventing the recurrence of bipolar disorder heavily favor the use of lithium for many patients. However, lithium should generally not be given to patients with significant myocardial or cardiovascular disease or in the presence of severe renal disease, organic brain disease, or pregnancy (see below).

Renal damage from long-term lithium therapy is a controversial issue. Morphological changes with glomerular and interstitial fibrosis and nephron atrophy have been reported in patients who underwent chronic lithium therapy for many years (20). However, similar lesions have been found in patients before beginning lithium therapy, so lithium cannot be regarded as specifically nephrotoxic. Nevertheless, the dose of lithium should be kept low to minimize the uncertain risk that long-term lithium use may result in renal damage.

Table 2A.3.
Drug Interactions with Lithium

Interacting Drug	Mechanism/Effect/Management
Carbamazepine or haloperidol	Rare neurotoxicity from an unknown mechanism; closely monitor patients receiving these combinations.
Ibuprofen or indomethacin	Decreased lithium clearance possibly from inhibition of renal prostaglandin synthesis; result is increased serum lithium; adjust lithium dose or consider using aspirin.
Naproxen	Decreased lithium clearance by unknown mechanism; monitor lithium serum concentration closely.
Iodide salts	Additive effects in causing hypothyroidism; discontinue iodide salts or give thyroid replacement if needed.
Furosemide, ethacrynic acid or bumetanide	Possible elevated serum lithium from decreased renal excretion; adjust lithium dose if needed.
Theophylline	Increased renal excretion of lithium; monitor serum levels and adjust dose if needed.
Thiazide diuretics	Decreased renal excretion of lithium results in elevated lithium levels, which can lead to serious toxicity; use of a loop diuretic may be preferable.

Table 2A.4.
Side Effects of Lithium

- Mild and Usually Transient
  - Nausea, abdominal discomfort, mild diarrhea
  - Polydipsia, polyuria
  - Fine hand tremor
  - Muscular weakness, fatigue, lethargy
  - Generalized discomfort
- Suggesting Early or Moderate Lithium Toxicity
  - Severe GI distress—nausea, vomiting, severe diarrhea
  - Anticholinergic-like symptoms—blurred vision, dry mouth
  - Muscular weakness
  - Coordination impairment, ataxia
  - Confusion, drowsiness, irritability
- Acute or Severe Lithium Toxicity
  - Impairment of consciousness, stupor, coma
  - Neuromuscular asymmetries—nystagmus
  - Coarse tremor
  - Epileptiform seizures
  - Hyperreflexia
  - Slurred speech, vertigo, somnolence
  - Arrhythmias, hypotension, peripheral circulatory failure
  - Respiratory depression

B

Imipramine Database

FORMULATIONS

Imipramine hydrochloride tablets: 10 mg, 25 mg, 50 mg
Imipramine hydrochloride capsules: 125 mg, 150 mg, 200 mg
Imipramine hydrochloride injection: 25 mg/ml
Brand names: Tofranil (Geigy); Janimine (Abbott); SK-Pramine (SKF); various generic brands

Table 2B.1.
Expected Physiological Effects from Imipramine Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Frequent increase of up to 10 beats/min persisting throughout therapy
ECG	Prolonged QRS greater than 100 msec when plasma concentrations exceed 1000 ng/ml; reduced T-wave amplitude, rarely at usual plasma concentrations
Blood pressure	Orthostatic hypotension is common in up to 20% of treated patients.
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults.
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Transient benign increases may occur during 1st mo. Substantial increases accompanied by increases in bilirubin should prompt further assessment of liver function. Imipramine- and desipramine-associated hepatitis has been reported.
Hematology status	
CBC	Rare, transient increases in eosinophils; decreases in leukocytes; trivial decreases in platelet count
Neuroendocrine status	
DST, plasma cortisol	Therapy not expected to interfere with DST; frequent normalization of DST with successful antidepressant therapy
Other tests	
EEG	Decreased REM sleep

[a] For abbreviations, see Table 2A.1. DST, dexamethasone suppression test; EEG, electroencephalogram.

Table 2B.2.
Pharmacokinetic Parameters of Imipramine

Parameter	Range
Bioavailability	Nearly complete absorption; total bioavailability reduced from extensive presystemic elimination to 30 to 70%
Time of peak concentration after single dose	Between 2 and 8 hr
Plasma protein binding	85 to 96%
Volume of distribution	10 to 30 liters/kg
Total plasma clearance	30 to 100 liters/hour
Renal clearance	Negligible
Elimination half-life	6–28 hours, increasing with age after adulthood
Active metabolites	Desipramine, 2-hydroxyimipramine, 2-hydroxydesipramine
Steady-state metabolite-to-parent concentration ratio	DMI:IMI average of 1.5 2-OH-IMI:IMI average of 0.2 2-OH-DMI:DMI average of 0.5
Therapeutic range for antidepressant effect	180 to 350 ng/ml of combined imipramine plus desipramine in adults; 120 to 250 ng/ml in children

INDICATIONS

Imipramine is FDA approved for the relief of symptoms of depression and depression accompanied by anxiety. In addition, IMI is the only tricyclic antidepressant with a specific FDA approval for the treatment of enuresis. Imipramine and other tricyclic antidepressants have been tried with some success for various mental and medical disorders listed in Table 2B.3.

Imipramine's use for depression, especially endogenous depression, is its primary indication. These patients will frequently have sleep disturbances, diurnal mood variation, loss of weight and libido, and psychomotor retardation, the neurovegetative signs not consistently present in less ill patients. Of endogenously depressed patients, 60 to 70% should respond well to IMI.

For depressed patients presenting with delusions, there is controversy over whether electroconvulsive therapy should be considered as the treatment of choice (7, 8). The more severe an illness, the more easily recognizable is clinical improvement, and this is true for depression. Therefore, it may be more diffi-

Table 28.3.
Conditions for Which Imipramine or Tricyclic Antidepressants May Have Beneficial Effects

Condition	Efficacy Monitoring Parameters
Anorexia nervosa	Weight gain; improvement in appetite, self-concept
Attention deficit disorder	Decrease in distractibility; increased attention span; improved behavior
Bulimia nervosa	Decreased binging episodes
Enuresis	Decreased bed or daytime wetting frequency
Encopresis	Reduction in soiling
Posttraumatic stress disorder	Decreased startle response, anxiety, rumination, nightmares
Panic disorder	Decreased anxiety; fewer panic episodes; less avoidance behavior
Migraine headache	Decreased frequency or intensity or duration
Obesity	Weight loss, decreased craving, self-control
Peptic ulcer disease	Decreased epigastric pain, GI distress
Premature ejaculation	Reports of improved sexual performance

cult to perceive improvement in patients with milder forms of depression without a good assessment of premorbid functioning. However, nonendogenous, or neurotic, depression also responds well to imipramine therapy (9). Schizophrenic patients frequently have a high incidence of depressive symptoms during a postpsychotic state. This syndrome can be confused with akinesia, but IMI has produced good improvement in these patients' affective states (10).

Imipramine has been shown to be effective for treatment of panic disorder. The onset of significant effectiveness may be slow, but 60 to 90% of patients can be expected to show some improvement.

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

It should be remembered that many depressed patients will be suicidal. Unfortunately, the tricyclic antidepressants can be fatal in overdose and, therefore, a large prescription quantity should be avoided in outpatients. The dose of IMI producing fatalities is highly variable. A child has died from an ingestion as low as 350 mg, and adults have survived overdosages between 5 and 10 gm (17).

Patients with open-angle glaucoma can be safely treated with IMI, but those with angle closure should have a referral to an ophthalmologist. IMI has the potential to aggravate glaucoma, especially narrow angle, as its anticholinergic effects can precipitate acute symptoms. In patients over the age of 40, a history of "halos" around lights associated with eye pain should prompt an ophthalmic examination.

During maintenance therapy of patients with bipolar (manic-depressive) disorder, imipramine may accelerate the switch from depression to mania. Monitoring for symptoms of hypomania would be appropriate in these patients. Lithium may be a useful addition to the therapy of these patients but may not always prevent the switch process from occurring (15).

Table 2B.4.
Drug Interactions with Imipramine

Interacting Drug	Effect
Barbiturates	Hepatic enzyme induction results in decreased imipramine plasma concentrations.
Methylphenidate, chloramphenicol, phenothiazines, cimetidine, oral contraceptives	Increased plasma concentration through hepatic enzyme inhibition
Thyroid hormone	Possibly increased antidepressant efficacy through an unknown mechanism
Dicumarol	Increased hypoprothrombinemic effect by an unknown mechanism
Clonidine, guanethidine	Decreased antihypertensive effect
Sympathomimetics (epinephrine, phenylephrine)	Enhanced α-adrenergic effects
Monoamine oxidase inhibitors	Increased adverse drug effects are possible. Close monitoring is mandatory. Allow 7 days between starting either one after discontinuing the other, or both may be started together (see Chapter 2D).

Table 2B.5.
Expected Side Effects of Imipramine Therapy

Effect	Rare	Less Common	More Common
Dry mouth			X
Blurred vision		X	
Gastrointestinal disorders		X	
Nausea		X	
Vomiting		X	
Drowsiness			X
Ataxia		X	
Disorientation	X		
Decreased energy			X
Headache		X	
Musculoskeletal complaints		X	
Blood pressure decrease		X	
Tachycardia		X	

C

Trazodone Database

FORMULATIONS

Trazodone hydrochloride tablets: 50 mg, 100 mg, 150 mg

Brand names: Desyrel (Mead Johnson); Dotazone (Major), various generic brands

Table 2C.1.
Expected Physiological Effects from Trazodone Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Occasional tachycardia accompaning orthostasis
ECG	Rare intracardiac conduction disturbances
Blood pressure	Hypotension upon chronic therapy in susceptible individuals, more frequent in elderly but less frequent or severe than with tricyclic drugs
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	No changes expected other than minor increases within normal limits
Hematology status	
CBC	Occasional minor decreases in leukocytes and neutrophils, clinically insignificant unless below normal limits
Neuroendocrine status	
Plasma prolactin	Both increases and decreases reported, but little change is to be expected.
DST, plasma cortisol	Therapy not expected to interfere with DST; frequent normalization of DST with successful antidepressant therapy

[a] For abbreviations, see Table 2B.1.

Table 2C.2.
Pharmacokinetic Parameters of Trazodone

Parameter	Range
Bioavailability	70 to 90%
Time of peak concentration after single dose	0.5 to 3 hours
Plasma protein binding	89 to 95%
Volume of distribution	1.0 to 2.0 liters/kg; increased in obesity
Total plasma clearance	120 to 200 ml/min
Renal clearance	Negligible
Elimination half-life	3 to 14 hours
Active metabolites	*m*-Chlorophenylpiperazine
Steady-state plasma metabolite-to-parent concentration ratio	Less than 1.0
Therapeutic range for antidepressant effect	Inadequately defined

INDICATIONS

Trazodone is FDA-approved for treatment of depression. This indication can be further defined as "major depressive disorder," as described in DSM-III-R (see Chapter 1F). Controlled clinical trials, including double-blinded studies, have been conducted in both depressed inpatients and outpatients (1). Improvement in depression is similar to that observed with the prototype tricyclic antidepressants, imipramine and amitriptyline, with a reported complete remission rate of 46 to 70%. As occurs with all available antidepressants, some patients will be relative nonresponders and might benefit from an alternative therapy

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Although trazodone may cause some cardiac side effects, principally tachycardia, orthostasis, and, rarely, conduction disturbances, its use is associated with fewer and less severe cardiac effects than use of the traditional tricyclic antidepressants (11). Trazodone should not be administered to any patient with a recent myocardial infarction. In patients with cardiac disease, caution should be exercised. Arrhythmias have occurred in some patients with preexisting cardiac disease who took trazodone.

The effects of trazodone treatment for a week on the blood pressure response to tyramine, in comparison to the effects of placebo, were similar (12). This is in contrast to the effects of imipramine on systolic blood pressure after tyramine administration, an effect mediated by norepinephrine. The main cardiovascular effects of trazodone to monitor are blood pressure and pulse rate. Complaints of dizziness should be sought in any patient with a history of orthostasis. Several reports suggest that trazodone may elevate serum digoxin levels. Digoxin concentrations should be monitored when this combination of drugs is used.

Some unipolar depressed patients have been reported to develop manic symptoms when treated with trazodone (13). Thus, trazodone does not preclude this phenomenom, but it may be similar to the tricyclic antidepressants in having a propensity to initiate the switch process in occasional bipolar depressed patients.

Trazodone has been tested in patients with open angle glaucoma and found to decrease intraocular pressure (2). However, studies have not been reported in glaucoma patients with depression receiving chronic trazodone therapy, so caution should be exercised with these patients. As with the tricyclics, those patients with angle-closure disease may be at risk for increased intraocular pressure. However, given trazodone's lack of anticholinergic effects, it may be an appropriate alternative to tricyclic antidepressants in glaucoma patients who have had difficulty in the past with antidepressant therapy.

Table 2C.3.
Expected Side Effects of Trazodone Therapy

Effect	Rare	Less Common	More Common
Dry mouth			X
Blurred vision		X	
Gastrointestinal disorders		X	
Nausea		X	
Vomiting		X	
Drowsiness			X
Ataxia		X	
Disorientation	X		
Decreased energy			X
Headache		X	
Musculoskeletal complaints		X	
Blood pressure decrease	X		
Tachycardia	X		
Priapism	X		

D

Phenelzine Database

FORMULATIONS

Phenelzine tablets: 15 mg
Brand name: Nardil (Parke-Davis)

Table 2D.1.
Types of Monoamine Oxidase, Their Substrates, and Inhibitors

	Type of Enzyme	
	Type A	Type B
Substrates		
Serotonin	+	
Phenylethylamine		+
Norepinephrine	+	
Dopamine		+
Tyramine	+	+
Inhibitors		
Clorgyline	+	
Deprenyl		+
Harmaline	+	
Pargyline		+
Tranylcypromine	+	+
Phenelzine	+	+
Isocarboxazid	+	+

Table 2D.2.
Expected Physiological Effects from MAOI Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Slight decrease of approximately 5 beats/minute
ECG	Occasional decreased QTC intervals with normal QRS intervals
Blood pressure	A reduction occurs frequently, especially decreased systolic blood pressure upon standing; an enhanced pressor sensitivity to tyramine and sympathomimetic drugs occurs early in therapy and may persist for weeks after therapy is stopped.
Renal function	
Serum creatinine and clearance, BUN	No changes expected
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Hepatocellular damage is rare but has been reported in a few patients. No changes are expected outside normal limits.
Hematology status	
CBC	Leukopenia has been reported but is rare.
Neuroendocrine status	
DST, plasma cortisol	May normalize with successful therapy
Fasting blood glucose	MAOIs may lower blood glucose and improve glucose tolerance.

[a]For abbreviations, see Table 2B.1.

INDICATIONS

Phenelzine is FDA-approved for treatment of depressed patients clinically characterized as atypical, nonendogenous, or neurotic. These patients often have mixed anxiety and depression and phobic or hypochondriacal features. Thus, the target symptoms for monitoring clinical response will differ somewhat from the classical symptoms of endogenous depression. Table 2D.3 compares typical clinical features of these two types of depressed patients. There is current research activity in further defining this heterogenous group of patients (9, 10).

Phenelzine should rarely be the first antidepressant drug of choice, except in patients with atypical depression. Rather, it may be more suitable for use with patients who have failed to respond to either one or more cyclic antidepressants or lithium. Overall, the low degree of cardiac toxicity and apparent absence of central anticholinergic toxicity with phenelzine, as compared to those factors in the tricyclics, may be considered an advantage in some patients.

Reviews of controlled trials of MAOIs, including phenelzine, suggest an improvement rate of approximately 70%. This is similar to the improvement seen with tricyclic antidepressants. Perhaps more importantly, it should be understood that MAOI responders may have different clinical features than have tricyclic responders (11, 12). There is less conclusive evidence of phenelzine's usefulness with severely depressed patients with endogenous features (32, 33).

Phenelzine has several unapproved uses. The antiphobic effects of phenelzine have been well demonstrated, and the drug is most likely to be the agent of choice in the treatment of agoraphobia and social phobias (13, 14). Phenelzine is equal to or better than imipramine in the treatment of panic disorder. Limited research indicates that MAOIs, especially phenelzine, may be used successfully in patients with migraine headache refractory to other treatment (15). Phenelzine has also been effective in the treatment of bulimia (16).

In recent years, there has been wider recognition of posttraumatic stress disorder (PTSD), especially in Vietnam War veterans. These patients frequently have generalized anxiety and panic attacks (17). A favorable response has been noted in patients treated with phenelzine to relieve the anxiety and depressive symptoms associated with PTSD (18). As phenelzine depresses REM sleep in animals and humans, it can be expected to decrease dream activity. Target symptoms may include nightmares and flashbacks when one is monitoring phenelzine therapy in patients with PTSD.

Table 2D.3.
Target Symptoms Suggested for Monitoring Antidepressant Response in Atypical or Endogenously Depressed Patients

Atypical	Endogenous
Difficulty initiating sleep	Early morning awakening
Hypersomnia	Diminished sleep
Weight gain	Weight loss
Food craving	Loss of appetite
Agoraphobia	Psychomotor retardation
Panic experiences	Loss of energy
Hypochondriasis	Suicidal ideation
Obsessive traits	Constriction of interests
Psychic anxiety	
Somatic anxiety	

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Phenelzine is contraindicated in patients with pheochromocytoma, congestive heart failure, or a known hypersensitivity to the drug. Phenelzine should be avoided in patients who must take concurrent sympathomimetic amines, guanethidine, or meperidine or who have diets high in tyramine content. These drug-drug and drug-food interactions are explained below.

Like other antidepressants, phenelzine may precipitate a manic reaction in patients with bipolar disorder (22). As lithium has been successfully used in combination with phenelzine (23), it may be useful to prevent rapid cycling in susceptible patients.

Patients have developed pyridoxine (vitamin B_6) deficiency while taking phenelzine. Patients who complain of numbness of the hands, shock-like feelings in the spine, or other symptoms suggesting a neurological origin, may have this problem. Treatment is easily accomplished with supplemental dietary pyridoxine. The recommended dose is 300 mg daily.

Table 2D.4.
Drug Interactions with Monoamine Oxidase Inhibitors

Interacting Drug	Effect
Amine-containing foods	Increased blood pressure; possible hypertensive crisis; can occur up to several weeks after discontinuing the MAOI
Anorexiants and other sympathomimetics: Amphetamine Ephedrine Fenfluramine Methylphenidate Pseudoephedrine Phenylpropranolamine	Elevated blood pressure with possible hypertensive crisis and intracranial hemorrhage can occur. This combination activates large quantities of endogenous catecholamines.
Guanethidine	The antihypertensive effect of this drug may be decreased by an unknown mechanism.
Insulin, sulfonylureas	An increased hypoglycemic effect may occur.
Levodopa	Enhanced effects of levodopa; possible hypertensive crisis
Meperidine, dextromethorphan	Cardiovascular instability, hyperpyrexia, agitation, and death have occurred.
Tricyclic antidepressants	The effects of both drugs can be increased, leading to enhanced clinical and/or toxic effects (see text).

Table 2D.5.
Dietary Restrictions Recommended for Patients Taking Phenelzine

- Foods high in tyramine content that must be avoided
  - Cheese, especially aged cheese (Limburger, Gouda, Edam, Cheddar)
  - Foods containing cheese (pizza, fondue, many Italian dishes)
  - Wine, particularly Chianti and red wines in general
  - Fermented or aged foods, especially meats or aged fish (pepperoni, summer sausage, pickled herring)
  - Broad bean pods
  - Chicken or beef liver
  - Yeast extracts
- Foods with moderate tyramine content that are best avoided
  - Other alcoholic beverages (gin, vodka, whiskey)
  - Avocados
  - Yogurt
  - Bananas
  - Raisins, figs
  - Soy sauce
- Foods relatively low in tyramine content that can be consumed in moderate amounts
  - Bread
  - Cottage and cream cheese
  - Chocolate
  - Coffee, tea, and caffeine-containing beverages
  - Other fresh fruits

Table 2D.6.
Expected Side Effects of Phenelzine Therapy

Effect	Rare	Less Common	More Common
Dry mouth			X
Nausea			X
Headache		X	
Constipation			X
Blurred vision		X	
Orthostatic hypotension			X
Hypertensive reaction		X	
Dizziness			X
Ataxia	X		
Muscle cramps		X	
Weakness, fatigue			X
Agitation		X	
Insomnia		X	
Excitement or hypomania		X	
Sexual dysfunction (anorgasmia, impotence)			X
Lupus-like skin reaction	X		

Table 2E.1.
Classification of Proven and Experimental Antidepressants and Their Usual Daily Doses

Medication	Daily Dose Range (mg)
Monoamine oxidase inhibitors	
Phenelzine	30–90
Tranylcypromine	30–50
Isocarboxazid	20–30
Clorgyline	5–10
Deprenyl	5–15
Cyclic antidepressants	
Monocyclics	
Bupropion	150–450
Fluvoxamine	50–300
Dicyclics	
Fluoxetine	20–80
Tricyclics	
Amitriptyline	50–300
Clomipramine	50–300
Desipramine	50–300
Doxepin	50–300
Imipramine	50–300
Nortriptyline	50–200
Protriptyline	15–60
Trimipramine	50–300
Tetracyclics	
Maprotiline	50–200
Oxaprotiline	50–150
Heterocyclics	
Adinazolam	30–90
Alprazolam	3–10
Amoxapine	150–450
Carbamazepine	400–1600
Trazodone	50–600

Table 2E.2.
Pharmacological Comparison and Relative Side Effect Profile for Some Prominent Cyclic Antidepressants

Drug	Predominant Neurotransmitter Effect	Sedation Potential	Muscarinic Blockade	Orthostatic Hypotension
Amitriptyline	Serotonin	High	High	High
Amoxapine	Norepinephrine	Weak	Weak	Weak
Bupropion	Dopamine	Weak	Weak	Weak
Doxepin	Norepinephrine	High	Moderate	Moderate
Desipramine	Norepinephrine	Moderate	Moderate	Moderate
Fluoxetine	Serotonin	Weak	Weak	Weak
Imipramine	Serotonin	High	High	High
Maprotiline	Norepinephrine	Moderate	Weak	Moderate
Nortriptyline	Norepinephrine	Moderate	Moderate	Moderate
Protriptyline	Norepinephrine	Weak	Moderate	Moderate
Trimipramine	Serotonin	High	High	High
Trazodone	Serotonin	High	Weak	Weak

Table 2E.3.
Pharmacokinetic Parameters of Cyclic Antidepressants

Drug	Oral Availability	Volume of Distribution (liters/kg)	Total Body Clearance (liters/hr)	Elimination Half-life (hr)	Fraction Unbound in Plasma	Active Metabolites
Alprazolam	0.95	1–2	6–140	7–18	0.30	α-Hydroxy
Amitriptyline	0.3–0.6	6–36	19–72	9–46	0.03–0.15	Nortriptyline
Bupropion	0.9	27–60	120–180	10–20	0.20	Hydroxybupropion
Carbamazepine	0.7–0.8	0.8–1.4		10–30; 12[a]	0.15–0.35	10,11-Epoxide
Clomipramine	0.4–0.6	9–25	23–122	15–60	0.02–0.10	Desmethyl
Desipramine	0.3–0.6	20–60	78–168	12–28	0.08–0.27	2-Hydroxy
Doxepin	0.2–0.5	10–30	41–60	8–25	0.15–0.32	Desmethyl
Fluoxetine	0.95	12–42	6–42	120 +	0.06	Norfluoxetine
Imipramine	0.2–0.7	10–25	32–102	6–28	0.04–0.37	Desipramine
Maprotiline	0.8	16–32	17–34	27–50	0.12	Desmethyl
Nortriptyline	0.5–0.7	15–23	17–79	18–56	0.07–0.13	10-Hydroxy
Protriptyline	0.7–0.9	15–30	8–23	54–120	0.01–0.10	Desmethyl
Trazodone	0.7–0.9	0.8–1.5	7–12	4–13	0.05–0.11	*m*-Chlorophenylpiperazine

[a] Carbamazepine induces its own metabolism, and patients on chronic therapy will have a decreased half-life.

Table 2E.4.
Recommendations for Using Cyclic Antidepressant Plasma Concentration Monitoring

Drug	Concentration Range (ng/ml)	Effect
Imipramine	180–350	This range of combined imipramine plus desipramine concentrations has correlated well in several studies with antidepressant effect in endogenous depression.
	Over 500	Behavior toxicity may occur; there is rarely any justification to exceed this combined concentration.
	Over 1000	Has frequently correlated with severe systemic toxicity requiring medical support; range also applies to other tricyclics.
Nortriptyline	50–150	Range best associated with antidepressant effects in endogenous depression
Amitriptyline	120–250	This combined amitriptyline plus nortriptyline concentration is the target for antidepressant effect.
	Over 500	Frequently associated with anticholinergic delirium
Desipramine	115–250	Target concentration for antidepressant effect

Valproic Acid Valproic acid is an anticonvulsant indicated for simple and complex absence seizures. Reports have also suggested that valproate has effects in manic patients similar to those seen with acute lithium therapy (20). It has been reported to be moderately useful in schizoaffective disorder (21). There is much less experience with this drug than with carbamazepine.

Dosage is 1000 to 1500 mg/day, starting with 250 to 500 mg/day. Periodic liver function tests are recommended, as hepatotoxicity has been reported. Other side effects are gastrointestinal in origin, principally nausea, vomiting, and anorexia. Anticholinergic and sedative effects are minor.

Clonazepam Clonazepam, an anticonvulsant benzodiazepine, has also been tried for mood stabilization (19). Doses in acutely manic patients, up to 40 mg/day, are substantially higher than the 2 mg/day usually needed for control of seizures. The drug is more sedating than carbamazepine but, if proven effective, could be a safer alternative than lithium or carbamazepine. In doses of 1.5 to 6.0 mg/day it has shown good antipanic effects.

INDIVIDUAL AGENTS

Traditional Anticonvulsants

Carbamazepine Carbamazepine (CBZ) demonstrates a remarkable structural resemblance to the tricyclic antidepressants (Fig. 2E.1; compare imipramine in Fig. 2B.1) It is an anticonvulsant agent with prominant antimanic properties (16, 17). It serves as an alternative for patients who are unable to tolerate lithium's side effects or who respond to lithium poorly. CBZ does not produce marked sedation or neuroleptic side effects. Patients with a rapid cycling disorder seem to respond well. CBZ may also be useful to ameliorate aggressive and violent behavior and may be useful for patients with schizoaffective disorders.

Slow increases in dosage are recommended, starting with 200 mg/day and increasing up to 1000 mg/day according to the clinical response. The effective dose range is between 400 and 1600 mg/day. A plasma concentration range of 6 to 12 μg/ml correlates to CBZ's anticonvulsant effects, but a strong correlation of CBZ response with plasma concentration in mania has not been reported. Nevertheless, it seems unnecessary to exceed a steady-state plasma concentration of 8 to 12 μg/ml to achieve good antimanic effects.

Table 2E.5.
Expected Physiological Effects from Carbamazepine Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	No cardiac instability expected; less effect on producing orthostatic hypotension than either MAOIs or tricylics. Rare reports of heart block; decreases in pulse rate should be evaluated.
ECG	
Blood pressure	
Renal function	
Serum creatinine and clearance, BUN	No changes expected
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Transient elevations may occur; some cases of hepatotoxicity have been reported. Baseline indices should be obtained; expect increases in 2–3 weeks.
Hematology status	
CBC	Regular lowering of white count can be expected. Discontinue therapy under any of the following conditions: WBC $< 3000/\text{mm}^3$ Neutrophils $< 1500/\text{mm}^3$ Erythrocytes $< 4.0 \times 10^6\ \text{mm}^3$ Hematocrit $< 32\%$ Platelets $< 100{,}000/\text{mm}^3$
Neuroendocrine status	
DST, plasma cortisol	False positives can occur. Carbamazepine causes escape from dexamethasone suppression. Carbamazepine enhances vasopressin function and hyponatremia may occur.

[a] For abbreviations, see Table 2B.1.

Alprazolam Among the benzodiazepines, alprazolam has been most extensively tested for its antidepressant potential (24, 25) (Fig. 2E.2). Its FDA-approved indications are anxiety and anxiety associated with depression. In clinical trials of depressed patients, dosage has been generally higher than required for antianxiety effects (4 to 10 mg/day). Alprazolam has distinct antidepressant effects equivalent to those of standard tricyclic drugs in controlling acute symptoms for up to 6 weeks, but the efficacy of long-term therapy for maintaining remission of depression is unsubstantiated.

Alprazolam has been conclusively proven to have antipanic effects and is potentially useful for other anxiety disorders, including posttraumatic stress disorder and obsessive-compulsive disorder. Dosage should be started low, approximately 1.5 mg/day or less, regardless of indication. Reports of difficulty in discontinuing the drug suggest the need for gradual tapering of the dose over an extended period

Cyclic Antidepressants

Amitriptyline Sedation and a high degree of anticholinergic side effects are problematic when using amitriptyline (Table 2E.2). For a patient with a history of a previous response to the drug, it will be the preferred choice for retreatment. However, for many patients, imipramine remains a more suitable first choice among the tricyclic drugs (Chapter 2B). A positive relationship between plasma amitriptyline concentration and response has been noted in several trials (11). A therapeutic plasma concentration range is 120 to 250 ng/ml for amitriptyline, combined with the concentration of its metabolite nortriptyline. However, several large studies that have found no usable relationship between amitriptyline plasma concentration and clinical efficacy for treatment of depression. The determination of plasma amitriptyline concentrations is indicated in selected patients who are nonresponders and when noncompliance or anticholinergic toxicity is suspected. Concentrations greater than 450 ng/ml have been highly correlated with anticholinergic delirium (26).

Bupropion This long-awaited monocyclic antidepressant (Fig. 2E.4) has several clinical advantages, as compared to the tricyclic antidepressants, which suggest that it may be a first choice for some patients (29, 30). It lacks any appreciable anticholinergic or sedative effects, and it is probably the safest among all of the cyclic antidepressants, with the exception of alprazolam, for patients with cardiac disease. Orthostatic hypotension occurs to a much lesser degree than with the tricyclic antidepressants. Bupropion produces little or no weight gain or impairment in sexual functioning. However, it has the major drawback of occasionally provoking unexpected generalized seizures. The risk is increased when dosage is escalated sharply, and dosage should be kept under 450 mg for most patients and below 600 mg/day for all patients. Monitoring parameters for this side effect include prodromal signs of seizure activity, including complaints of nervousness, an exaggerated startle response, and psychomotor irritability. Treatment consists of intravenous diazepam or phenytoin and discontinuance of bupropion. As bupropion's active metabolites have half-lives of greater than 24 hours (31), monitoring should be continued for several days after the drug is stopped.

Bupropion has not received extensive investigation for the presence of a therapeutic plasma concentration range. Golden et al (32) found a curvilinear relationship between antidepressant effect and plasma concentration of hydroxybupropion (HB), bupropion's principal active metabolite. HB concentrations greater than 1250 ng/ml were associated with poor clinical outcome. High metabolite concentrations causing toxic effects involving dopaminergic systems may be related to psychotic reactions seen in occasional patients (33).

Unlike two other antidepressants, imipramine and phenelzine, bupropion lacks efficacy for treatment of panic disorder with phobias. This may be related to its prodopaminergic effects.

Clomipramine Clomipramine is similar in structure, effect, and side effects to imipramine. The drug's potent effects on serotonin may relate to its clinical efficacy in depression. Also, there is evidence that it produces a better response in patients with obsessive-compulsive disorder (OCD) than do other cyclic antidepressants or standard anxiolytics (34). It may therefore be expected to alleviate anxiety in depressed patients. Clomipramine may well become the drug of choice in OCD and should become available in the United States in 1990. In well controlled studies, it has demonstrated marked antipanic effects. Daily doses are similar to those of the other major tertiary amine tricyclic drugs (Table 2E.1).

The response to clomipramine in OCD may be slow, requiring 4 to 6 weeks. Sometime a relapse in symptoms has been noted at 4 weeks, followed by further improvement. The overall improvement rate can be expected to be better than 50%. Patients should not be expected to become free of symptoms; however, their symptoms become less bothersome. Ironically, more symptoms may be reported as improvement occurs. Unfortunately, pharmacotherapy must be continuous for improvement to be sustained.

Desipramine As the major imipramine metabolite, desipramine has several clinical advantages over its precursor. It is less anticholinergic and sedating. In particular, it is favored as a pharmacological probe in animal and human studies because it possesses the most selective actions on norepinephrine of the available cyclic antidepressants. A plasma concentration range associated with therapeutic effects is between 115 and 250 ng/ml (11); however, this therapeutic range is not as well established as that of imipramine. Studies in people between 60 and 80 years of age have shown that, for optimal antidepressant effect, these patients seem to require plasma concentrations in the same range as are used with younger adults. However, an increased risk of side effects exists for the elderly.

Fluoxetine Fluoxetine (Fig. 2E.5) is a selective inhibitor of serotonin uptake with antidepressant effects comparable to those of the tricyclics (35). This neurochemical action suggests that fluoxetine may also be beneficial in the treatment of obsessive-compulsive disorder, but data from double-blind clinical trials to support this use have not yet appeared. Other unapproved uses of fluoxetine for which some data suggestive of efficacy exist include the treatment of obesity, decreasing food craving, and the treatment of alcohol abuse. Its use in the treatment of panic attacks seems to be accompanied by a high incidence of side effects, notably anxiety resembling overstimulation.

Fluoxetine and its active metabolite, norfluoxetine, have half-lives in the range of 7 and 14 days, respectively, a departure from the disposition kinetics of the previously marketed cyclic antidepressants. Thus, steady-state concentrations will not occur for several weeks of continuous dosing. The drug has shown only weak anticholinergic side effects. Common side effects include nausea, nervousness, and insomnia. Rare cases of excessive stimulation, when combined with monoamine oxidase inhibitors (MAOIs), have recently been reported. Such combinations are best avoided at present. Previous reports described a similar "serotonin syndrome" when L tryptophan was administered to patients along with a MAOI.

Recent reports have documented fluoxetine to provoke unexpected seizures in occasional patients. Whether this adverse reaction is dose-related is unknown. The long half-life of fluoxetine and its active metabolite suggest that dosage increases should be made no more frequently than every 1 to 2 weeks to allow full accumulation to steady state. Overall, the drug's advantages of low sedative potential and a lack of anticholinergic and cardiovasculer effects suggest that it could be the first choice of antidepressants for many patients.

Nortriptyline This demethylated metabolite of amitriptyline has a lower degree of anticholinergic side effects and sedation, as compared with that of its precursor (Table 2E.2). The extent of this difference makes nortriptyline an acceptable antidepressant for some patients when amitriptyline is not. Nortriptyline has another advantage. It has the most established therapeutic plasma concentration range of all available cyclic antidepressants (11). Several studies have replicated a range of 50 to 150 ng/ml as optimal for treatment of endogenous depression. Steady-state plasma concentrations either below or above this range can be adjusted by means of dosage changes if clinical effects do not seem to be as robust as anticipated. However, as with all dose- or concentration-response relationships, some responders will be below and above the accepted target range which usually encompasses 20 to 80% of the responders. Overall, nortriptyline's monitoring parameters are similar to those of imipramine.

Nortriptyline may be the tricyclic antidepressant of choice for patients with significant problems with orthostatic hypotension (37). A pretreatment orthostatic systolic pressure drop of 10 mm Hg or greater may actually predict a favorable response to nortriptyline (38).

Protriptyline As can be seen in Table 2E.3, protriptyline has the longest half-life of the available tricyclic antidepressants. In addition, its daily dose is less. This drug has gained the clinical reputation for being "activating" in occasional patients, rather than sedating, as is typical for other members of its drug class. It is similar to the remaining tricyclics in its indications and side effects.

Heterocyclic Antidepressants

Brand Names

Amitriptyline	-	Elavil
Doxepin	-	Sinequan, Adapin
Imipramine	-	Tofranil
Protriptyline	-	Vivactil
Nortriptyline	-	Aventyl, Pamelor
Desipramine	-	Norpramin
Amoxapine	-	Ascendin
Maprotiline	-	Ludiomil
Trazodone	-	Desyrel
Bupropion	-	Wellbutrin
Fluoxetine	-	Prozac
Clomipramine	-	Anafranil
Sertraline	-	Zoloft
Adinazolam	-	Deracyn (under investigation)
Paroxetine	-	(under investigation)

Table 1F.7.
Classification of Anxiety Disorders

- I. Panic disorder
  - A. Without agoraphobia
  - B. With agoraphobia
- II. Agoraphobia without history of panic disorder
- III. Social phobia
- IV. Simple phobia
- V. Obsessive-compulsive disorder
- VI. Posttraumatic stress disorder
- VII. Generalized anxiety disorder

Table 1F.8.
Target Symptoms for Monitoring Antianxiety Therapy

- Motor tension
  - Tremor
  - Muscle tension
  - Startle reactions
  - Inability to relax
  - Teeth grinding
  - Nail or lip picking
  - Sleep disturbances
  - Sensitivity to noise levels
- Autonomic hyperactivity
  - Sweating
  - Cardiac palpitations
  - Cold, clammy hands
  - Dry mouth
  - Frequent urination and urgency
  - Gastrointestinal discomfort, diarrhea
  - Paresthesias
  - High resting pulse and respiration rate
  - Faintness
  - Sighing
- Cognitive
  - Apprehensive expectations
  - Excessive worry
  - Rumination
  - Feelings of unreality
  - Avoidance behavior
  - Constant vigilance
  - Feelings of being "on edge"
  - Difficulty in concentration
  - Feelings of "pressure"

A

Diazepam Database

FORMULATIONS

Diazepam tablets: 2 mg, 5 mg, 10 mg
Diazepam capsules: 15 mg sustained release
Diazepam oral solution: 5 mg/ml
Diazepam injection: 5 mg/ml
Brand names: Valium (Roche); various generic brands

Table 4A.1.
Expected Physiological Effects from Diazepam Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	No effect or slight increase in patients with lung disease
ECG	No expected effects
Blood pressure	Modest reduction in systolic pressure after IV administration
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Rare elevation of AST and ALT; jaundice has been reported.
Hematology status	
CBC	Rare leukopenia and eosinophilia
Neuroendocrine status	
Cortisol	No change or decrease in plasma cortisol; potential interference with DST during chronic, high dose therapy
Thyroid indices	These may be altered, but the patient remains euthyroid.
Growth hormone	No change or increase
ACTH	No change or decrease

[a] Abbreviations: ECG, electrocardiogram; BUN, blood urea nitrogen; AST, aspartate aminotransferase; SGOT, serum glutamic-oxaloacetic transaminase; ALT, alanine aminotransferase; SGPT, serum glutamic-pyruvic transaminase; CBC, complete blood count; ACTH, adrenocorticotropic hormone; DST, dexamethasone suppression test.

INDICATIONS

Diazepam is effective for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. This Food and Drug Administration (FDA)-approved labeling statement implies efficacy in specific anxiety disorders as well as anxiety associated with medical conditions. The various anxiety disorders were outlined in Chapter 1F. Table 4A.3 lists various medical conditions that may be accompanied with anxiety symptoms amenable to benzodiazepine therapy. The benzodiazepines are the drugs of choice for most anxiety states, but they are not superior to the monoamine oxidase inhibitors or tricyclic antidepressants for treatment of panic disorder and agoraphobia (11).

Diazepam is useful in states of acute alcohol withdrawal (12). It reduces the agitation and associated symptoms of impending delirium tremens. Although

Table 4A.3.
Conditions for Which Diazepam or Benzodiazepines May Have Beneficial Effects

- Medical conditions with accompaning anxiety
  - Angina pectoris
  - Alcohol withdrawal states
  - Chronic obstructive pulmonary disease
  - Mitral valve prolapse
  - Myocardial infarction
  - Organic brain syndromes
  - Pain
  - Pheochromocytoma
  - Thyrotoxicosis
  - Trauma
- Anesthetic therapy
  - Tracheal intubation
  - Adaptation to ventilator rhythm
  - Psychomotor agitation
  - Eclampsia
  - Decerebrate fits
  - Tetanus
- Neurology
  - Postherpetic neuralgias
  - Spasticity
  - Tetanus
  - Status epilepticus

chlordiazepoxide has been promoted for this use, it has no inherent advantages over diazepam.

Diazepam has been commonly used as a premedication for numerous surgical conditions. As a preoperative, it is used parenterally before cardioversion and as an adjunct before endoscopic procedures.

Diazepam is used orally as a skeletal muscle relaxant. It decreases the severity of muscle contractions in stiff-man syndrome, a condition characterized by severe spasm of somatic musculature (trunk and abdominal wall) that may last for a few hours or up to a few days. Early studies with cats demonstrated that diazepam had high potency for inhibition of the linguomandibular reflex. It was better in this model of muscle relaxation than either *N*-desmethyldiazepam or oxazepam. This potency difference may account for diazepam's greater popularity as a muscle relaxant than other benzodiazepines. Diazepam is also used parenterally in the treatment of tetanus.

Diazepam administered 5 to 10 mg intravenously is useful in status epilepticus and recurrent convulsive seizures (13). It is also used to treat myoclonic and akinetic seizures and infantile spasms. It may be added to other anticonvulsant regimens in patients with generalized tonic-clonic seizures whose seizures are precipitated by tension and anxiety.

There is some evidence that diazepam may be an effective alternative to anticholinergics for the treatment of akathisia (14). Although this therapy is usually not considered until anticholinergic medications have failed, some evidence exists for successful use of diazepam in dystonic reactions that are otherwise unresponsive (15).

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Unwanted CNS depression can be expected to be worse in patients given diazepam for anxiety who have low serum albumin concentrations, less than 3.0 gm/100 ml (19). This adverse consequence of therapy may be a result of reduced plasma protein binding and increased free drug concentration. The elderly, patients with burns, or those with trauma may be at risk for greater side effects from usual doses due to decreased protein binding.

Table 4A.4.
Drug Interactions with Diazepam

Interacting Drug	Effect
Magnesium-aluminum antacids	Delays rate and possibly extent of absorption
Rifampin	Increases clearance
Isoniazid	Decreases clearance and prolongs elimination half-life
Disulfiram, cimetidine, oral contraceptives	Inhibits clearance
Nicotine	Cigarette smoking increases clearance and decreases clinical effects.
Phenytoin	Diazepam possibly interferes with phenytoin metabolism.
Alcohol	Additive depressant effects

Diazepam is water-insoluble and is marketed for injection dissolved in propylene glycol and ethanol. It precipitates if diluted for intravenous injection and causes phlebitis at the site of injection relatively frequently. It should not be mixed with other drugs or diluted but should be injected slowly, no faster than 5 mg (1 ml)/min. Diazepam adsorbs to plastic intravenous tubing and, therefore, the delivered dose may be less than that calculated. If patients are to receive diazepam intravenously, equipment for respiratory or cardiovascular assistance should be readily available as rare episodes of apnea have occurred.

Psychological and physical dependence is a risk associated with the chronic use of all benzodiazepines. These problems are more likely to occur with diazepam when therapy is prolonged and doses are excessive. Nevertheless, dependence from normal doses can occur.

When discontinuing therapy, a tapering schedule should be used. This will minimize the possibility of withdrawal symptoms. These are usually mild in character, consisting of flu-like symptoms mimicking cholinergic rebound. However, severe symptoms consisting of tremor and convulsions can occur. Propranolol has been used to attenuate the severity of benzodiazepine withdrawal symptoms, but its use cannot be expected to reduce the incidence of withdrawal symptoms.

Table 4A.5.
Expected Side Effects from Diazepam Therapy

Effect	Rare	Less Common	More Common
Dry mouth		X	
Blurred vision		X	
Gastrointestinal disorders		X	
Nausea		X	
Vomiting	X		
Drowsiness			X
Dizziness			X
Ataxia		X	
Fainting	X		
Disorientation		X	
Headache		X	
Restlessness	X		
Excitement	X		
Skin rash	X		
Blood pressure decrease		X	
Tachycardia		X	
Jaundice	X		

B

Buspirone Database

FORMULATIONS

Buspirone tablets: 5 mg, 10 mg
Brand names: BuSpar (Mead-Johnson)

INDICATIONS

Buspirone has been approved for the treatment of generalized anxiety disorder. Premarketing clinical trials demonstrated that buspirone was superior to placebo and as efficacious as standard benzodiazepines (diazepam or alprazolam) in the treatment of mild-to-moderate anxiety (10–12). Subtle differences between the benzodiazepines and buspirone in clinical trials suggest a basis for discrimination in drug selection for specific patients.

Compared to the benzodiazepines, buspirone may be more effective for anger and hostility associated with anxiety. Buspirone would be preferred in some patients with a history of aggression or loss of impulse control as disinhibition sometimes occurs with benzodiazepine use.

As buspirone has only a minimal effect in producing sedation, patients with psychomotor agitation may be better treated with a benzodiazepine. Also, for patients with a high degree of somatic anxiety and muscle tension, a benzodiazepine may be beneficial because of its sedative and muscle relaxant qualities.

For some patients who have never received an antianxiety drug, buspirone may be preferred because of its lack of sedation. Patients with a history of benzodiazepine use often have specific expectations from antianxiety therapy. These patients may become disappointed with buspirone's slow onset of therapeutic activity.

Buspirone has been shown in double-blind studies to be effective for relief of anxiety in the presence of depression (13); however, other data suggest that buspirone has equivocal effects as an antidepressant. At present, depression does not constitute an indication for buspirone. In anxious patients who do not respond adequately to buspirone therapy in several weeks, underlying depression should be suspected and treated specifically if found to exist.

Buspirone's dopaminergic activity would suggest possible beneficial effects for Parkinson's disease and schizophrenia (14, 15), disorders with a recognized pathophysiological basis involving dopamine. In limited studies, buspirone did not seem to have promising activity for either of these indications. Buspirone was tried in high doses, from 600 to 2400 mg/day, in 10 schizophrenic patients without success (15).

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Most sedatives interact adversely with alcohol and other CNS depressants. Buspirone is an exception. Buspirone can cause drowsiness and fatigue, but these effects are usually minimal and caused no impairment of driving-related skills (16, 17). In addition, buspirone was found to lack euphoriant effects or addictive potential (18). Some patients may experience dizziness if single doses as high as 40 mg are taken. Buspirone may be preferred for patients who are likely to combine antianxiety therapy with depressants like alcohol.

For patients receiving benzodiazepines who are switched to buspirone, tapering of the benzodiazepine must be initiated as buspirone does not block benzodiazepine withdrawal symptoms. It is recommended that the same benzodiazepine dose be kept until buspirone has been titrated up to an acceptable daily dose, around 30 mg/day. At this time, the benzodiazepine dose can be slowly decreased. Similarly, when buspirone must be discontinued, tapering should also be instituted, although a specific withdrawal syndrome has not yet been described.

Table 4B.3.
Drug Interactions with Buspirone

Interacting Drug	Effect
Haloperidol	Buspirone may inhibit metabolism and raise haloperidol plasma concentrations.
Trazodone	The combination has resulted in elevation of hepatic enzymes, but no definite pharmacodynamic interaction has been noted. Attempts to replicate this interaction have not been successful.
Amitriptyline, nortriptyline	No kinetic or dynamic interaction reported
Monoamine oxidase inhibitors (phenelzine or tranylcypromine)	Elevations in blood pressure

Table 4B.4.
Expected Side Effects from Buspirone Therapy

Effect	Rare	Less Common	More Common
Gastrointestinal complaints			X
Nausea			X
Drowsiness		X	
Dizziness			X
Headache			X
Nervousness			X
Skin rash	X		
Sweating/clamminess		X	
Galactorrhea	X		

C

Intraclass Comparisons of Anxiolytics

Table 4C.1.
Pharmacological Comparison of Benzodiazepines

Basis of Comparison	Clinical Implication
Intrinsic potency	Partly determines differences in daily milligram dose administered to achieve equivalent antianxiety effects (see Chapter 1C)
Absorption rate	Rate-limiting step for entry of drug into the brain; affects onset of acute clinical effects. The greater the lipid solubility, the faster the rate and onset of action.
Plasma protein binding	The smaller the fraction bound in plasma, the greater the amount of drug available to diffuse into the brain.
Volume of distribution	Along with clearance, one of the two major determinants of half-life; a reflection of the extent of drug distribution beyond the systemic circulation (see Chapter 1D).
Hepatic clearance	Determines the extent of drug accumulation at steady state; along with volume of distribution, determines the half-life and therefore the time to achieve steady state and time for drug to wash out of the body after stopping therapy; relates to duration of action (see Chapter 1D)
Predominant metabolism by oxidative pathways (phase I)	Production of active metabolites; predicts prolonged half-lives in elderly, greater likelihood of some drug interactions and influence on disposition from liver disease
Predominant metabolism by conjugation pathways (phase II)	Less influence from ageing, smoking, liver disease, enzyme inhibitors on elimination rate

Table 4C.2.
Benzodiazepine Anxiolytics and Their Usual Daily Oral Doses

Medication	Brand Names	Daily Dose Range (mg)
Alprazolam	Xanax	1–4
Clorazepate	Tranxene	15–60
Chlordiazepoxide	Librium, other generics	15–60
Diazepam	Valium, other generics	4–40
Halazepam	Paxipam	60–160
Lorazepam	Ativan	1–6
Oxazepam	Serax, other generics	10–120
Prazepam	Centrax	20–60

Table 4C.4.
Effects of Ageing on Half-life of Some Benzodiazepines

Drug	Half-life (hours)	
	Healthy Adults	Elderly
Alprazolam	6–16	12–27
Diazepam	20–70	30–200
Desmethyldiazepam	36–96	45–200
Flurazepam (desalkylflurazepam)	35–150	70–290
Oxazepam	5–15	5–20

INDIVIDUAL AGENTS

Alprazolam

Among the benzodiazepines, alprazolam has the most proven effectiveness for treatment of panic disorder (24). Clonazepam ranks second, and only limited data exist for the efficacy of diazepam. The usual effective oral daily dose range of alprazolam for anxiety is 1 to 4 mg/day but, for effective treatment of panic disorder, the daily dosage may range up to 6 mg/day. Pharmacokinetic studies suggest that alprazolam should be effective when administered sublingually as the completeness of absorption has been shown to be similar to that with the oral route. This may be useful information for an occasional patient.

Alprazolam is also distinguished by having shown effectiveness for depression and anxiety associated with depression (25). Several multicenter trials found it to be equivalent in many standard measures to cyclic antidepressants. However, the dosage at which antidepressant effects occur, in the range of 4 to 8 mg/day, is generally higher than doses needed for anxiolytic effects.

Alprazolam has been the most thoroughly studied benzodiazepine for antidepressant effects. The possibility exists that other benzodiazepines may also be useful for depression. Adinazolam, another triazolobenzodiazepine, is currently in clinical trials for this indication.

The moderate half-life of alprazolam, in the range of 6 to 16 hours, means that plasma concentrations will fall substantially during a twice daily dosage schedule. This has led to the reemergence of panic symptoms in some patients. Thus, a more frequent dosage schedule may be necessary to maintain the duration of action. Monitoring of daily symptoms (Chapter 1F) will help determine this need.

Like the other benzodiazepines, alprazolam has been implicated as causing withdrawal symptoms when therapy is stopped. There is controversy as to whether alprazolam may be worse than other benzodiazepines in this characteristic (26). The drug should be tapered when discontinued to minimize these effects. Some patients could benefit from overlap with another, long-acting benzodiazepine when discontinuing alprazolam. Diazepam, in a dosage of 10 mg/day for each 1 mg of alprazolam per day, has been recommended with a tapering schedule of 10 mg weekly. Clonazepam (half-life of 45 hours) has proven successful for this situation. Any of the benzodiazepines with long half-lives should help in discontinuing alprazolam. A preferred approach is to use a slow tapering schedule, decreasing the daily dose by only 0.5 mg/week. This usually avoids withdrawal problems in most patients. However, anxiety disorders such as panic disorder are chronic in their clinical course, and reemergence of symptoms may occur during the attempt to discontinue drug therapy. Buspirone will not suppress benzodiazepine withdrawal symptoms and cannot be used for this purpose.

Clonidine

Clonidine is an α_2-agonist marketed as an antihypertensive drug. It has been useful in clinical psychopharmacology for moderating the withdrawal from opiate addiction (27). It has been proposed as a treatment for various mental disorders, including schizophrenia, Korsakoff's psychosis, tardive dyskinesia, obsessive-compulsive disorder, and Gilles de la Tourette syndrome, and for reduction of the craving for alcohol, nicotine, and cocaine (28). Most studies have found limited effectiveness for these indications. Studies of clonidine in panic anxiety have suggested only a moderate effect (29). A tolerance to its benefits has also been noted with a decrease in efficacy over time.

There are theoretical reasons for manipulating the noradrenergic system in anxiety disorders (30), and clonidine is likely to continue to be investigated as a psychopharmacological agent. Its physiological effects for monitoring are summarized in Table 4C.5.

The use of clonidine is complicated by side effects. Most prominent are those affecting the cardiovascular system. Mean arterial blood pressure will decrease during therapy. Frequent side effects include sedation, dry mouth, and constipation. Less frequent effects are changes in sleep patterns, nightmares, headaches, and disturbances in sexual function. Of concern is the rebound in blood pressure that may occur upon abrupt discontinuation of clonidine. Within 12 to 24 hours after stopping the drug, restlessness, irritability, and tremor may occur. Behavioral symptoms such as anxiety and nervousness have been noted. Rapid withdrawal should be avoided by tapering the drug when stopping therapy.

Table 4C.5.
Expected Physiological Effects from Clonidine Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Decrease within 30 minutes after oral dose, peak at 2 hours, lasting 24 to 36 hours
Blood pressure	Decrease in systolic and diastolic Rebound hypertension if drug is abruptly stopped
ECG	Rare A-V block; digitalis may predispose patients to this effect.
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change.
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Transient increases during therapy
Hematology status	
CBC	No changes expected
Neuroendocrine status	
Cortisol	No changes expected
Other observations	Acute and sustained decreases in plasma epinephrine and norepinephrine

[a] For abbreviations, see Table 4A.1. A-V, atrioventricular.

D

Flurazepam Database

FORMULATIONS

Flurazepam capsules: 15 mg, 30 mg
Brand names: Dalmane (Roche); various generic brands

Table 4D.1.
Expected Physiological Effects from Flurazepam Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	No effects are expected unless a slight slowing.
ECG	No expected effects
Blood pressure	Mild and clinically unimportant decrease
Renal function	
Serum creatinine and clearance, BUN	Normal values should not change in most adults.
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Normal values should not change in most adults.
Hematology status	
CBC	Normal values should not change in most adults. Rare case of leukopenia is reported.
Neuroendocrine status	
Cortisol	Normal values should not change in most adults.

[a] For abbreviations, see Table 4A.1.

INDICATIONS

Flurazepam is approved for the short-term (up to 4 weeks) treatment of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakening. Flurazepam can be used effectively in patients with recurring insomnia or poor sleeping habits. Because the long-acting metabolite accumulates during 2 weeks of continuous therapy, a "carryover" or hangover effect occurs frequently. As a result, flurazepam can be more effective on the second and third nights of administration than on the first night. The slow clearance of the metabolite and its persistence in the body after flurazepam dosing is discontinued explain why sedative effects continue for 1 to 2 nights after the drug is discontinued. This long duration of action minimizes any rebound of REM sleep. Flurazepam is superior to the older barbiturates as a sedative (7). The drug is not approved for the treatment of anxiety although, as a benzodiazepine, flurazapam could be expected to have antianxiety effects.

Although flurazepam is indicated for symptomatic relief of insomnia, the cause of sleep complaints should always be sought. Depression, anxiety, and other mental or medical disorders can result in poor sleep. Reviews of rational sedative-hypnotic prescribing are readily available (8, 9).

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Contraindications include known hypersensitivity to flurazepam and use in pregnancy (see below). Physical and psychological dependence are rare in patients taking flurazepam; however, prolonged therapy with doses greater than those recommended increases the risks.

Benzodiazepines are subject to abuse and dependence. Withdrawal symptoms may occur after the abrupt discontinuance of dosing; however, this problem may be less with flurazepam than other sedative-hypnotics because of the slow elimination of desalkylflurazepam.

Flurazepam may impair physical and/or mental abilities required for operating a motor vehicle or other hazardous machinery. Ambulatory patients should be cautioned accordingly about engaging in such activities while taking this drug.

Flurazepam has the potential for additive effects with alcohol and other CNS depressants. The potential for this interaction continues for several days after discontinuation of the drug, until substantial amounts of active metabolites have been eliminated.

It is recommended that the dose of flurazepam be limited to 15 mg for elderly and debilitated patients because the risk of oversedation, dizziness, confusion, or ataxia is substantially increased with larger doses in such patients (5, 14). Flurazepam should be used with caution in patients with impaired renal or hepatic function and chronic pulmonary insufficiency.

Table 4D.3.
Expected Side Effects from Flurazepam Therapy

Effect	Rare	Less Common	More Common
Dry mouth		X	
Blurred vision		X	
Nausea		X	
Vomiting		X	
Diarrhea			
Drowsiness			X
Dizziness			X
Ataxia			X
Mental confusion			X
Disorientation			X
Headache		X	
Restlessness or paradoxical stimulation	X		
Difficult urination	X		
Constipation		X	
Hypotension		X	
Tachycardia	X		
Jaundice	X		

Table 1F.9.
Major Child and Adolescent Mental Disorders Having Pharmacotherapy Treatment Options

- I. Disruptive behavior disorders
  - A. Attention-deficit hyperactivity disorder
  - B. Conduct disorder
- II. Eating disorders
  - A. Anorexia nervosa
  - B. Bulimia nervosa
- III. Tourette's disorder
- IV. Elimination disorders
  - A. Enuresis
  - B. Encopresis
- V. Autistic disorder

Table 1F.10.
Target Symptoms for Monitoring Response to Treatment in Attention-Deficit Hyperactivity Disorder

Decreased attention span
Distractability
Irritability
Poor cooperation with authority figures
Low self-esteem
Lack of motivation
Shouting at siblings, peers, and adults
Low alertness
Social withdrawal
Verbal production

A

Methylphenidate Database

FORMULATIONS

Methylphenidate tablets: 5 mg; 10 mg; 20 mg; 20 mg in a sustained release formulation
Brand names: Ritalin (Ciba); various others

Table 5A.1.
Expected Physiological Effects from Methylphenidate Therapy for Monitoring[a]

Parameter	Drug Effect
Cardiovascular status	
Heart rate	Can be expected to increase 10 beats/minute or more
ECG	
Blood pressure	Slight increases in systolic and diastolic pressure have been noted.
Renal function	
Serum creatinine and clearance, BUN	Normal values are not expected to change.
Hepatic function	
AST (SGOT), ALT (SGPT), alkaline phosphatase	Normal values should not change in most patients.
Hematology status	
CBC	An occasional case of eosinophilia has been noted. A hematological screen is recommended once a year.
Neuroendocrine status	
Cortisol	No effect expected

[a]Abbreviations: ECG, electrocardiogram; BUN, blood urea nitrogen; AST, aspartate aminotransferase; SGOT, serum glutamic-oxaloacetic transaminase; ALT, alanine aminotransferase; SGPT, serum glutamic-pyruvic transaminase; CBC, complete blood count.

INDICATIONS

The major indication for methylphenidate is in the treatment of ADHD. Before the advent of DSM-III-R, patients with ADHD were frequently diagnosed as having minimal brain dysfunction or hyperkinetic child syndrome. Patients with ADHD are usually children older than 7 years of age, although symptoms will have been present before this age. These children show inappropriate degrees of inattention, impulsiveness, and hyperactivity. These behaviors often lead to difficulties in school performance and maintaining constructive relationships with family members and peers.

Methylphenidate has been proven in double-blind, placebo-controlled studies to improve behavior, concentration, and learning ability in most children with ADHD (8). It has been compared to other psychostimulants and found to be superior to caffeine and amphetamine (9). Methylphenidate has the advantage of producing fewer adverse effects than amphetamine.

Other uses for methylphenidate include symptomatic treatment of narcolepsy and treatment of apathetic or withdrawn behavior due to a variety of causes, including depression. Its effectiveness for these uses is not completely established.

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

Methylphenidate should not be used in a patient with a history of marked anxiety, tension, and agitation because it may aggravate these symptoms. It is also contraindicated in patients who are hypersensitive to the drug, patients with glaucoma, and patients with motor tics, a family history or diagnosis of Gilles de la Tourette's syndrome, or anorexia nervosa. In developmental disorders that resemble adult schizophrenia, methylphenidate could exacerbate psychotic symptoms and should be avoided.

Methylphenidate should not be used for severe depression or for the prevention or treatment of normal fatigue states. In patients with hypertension and patients with a prior history of seizures, methylphenidate should be used with caution, if at all.

During prolonged therapy it is advised to have periodic complete blood counts and differential and platelet counts, especially in children. The drug should be administered with caution to adults with a history of drug dependence because such patients may increase the dosage on their own initiative. Chronic excessive use may result in a marked tolerance and psychic dependence.

Table 5A.3.
Expected Side Effects from Methylphenidate Therapy

Effect	Rare	Less Common	More Common
Headache		X	
Insomnia			X
Drowsiness		X	
Loss of appetite			X
Loss of weight		X	
Nausea		X	
Abdominal pain		X	
Nervousness			X
Mood changes		X	
Dry mouth		X	
Blurred vision		X	
Disorientation	X		
Tic-like movements of head, face	X		
Skin rash	X		
Blood pressure increase		X	
Tachycardia		X	
Anemia	X		

Table 1F.11.
Target Symptoms for Monitoring Response to Treatment for Psychoactive Substance Use Disorders

Drug-seeking behavior
Craving
Anxiety
Rumination
Guilt

A

Disulfiram Database

FORMULATIONS

Disulfiram tablets: 250 mg, 500 mg
Brand names: Antabuse (Ayerst); various generic names

INDICATIONS

Disulfiram is indicated as an aid in the management of alcoholism. There are limited data from controlled clinical trials of its efficacy in maintaining long-term sobriety (6). Patients do best who are highly motivated and who feel the need for an external aid in an abstinence program.

The effectiveness of disulfiram depends on the patient's willingness to initiate and comply with treatment. In one study (7), patients who accepted disulfiram tended to be younger and were more likely to be acceptors of most other types of treatment recommendations for problem drinking. A large number of alcoholics refuse to take the drug. Psychological testing has suggested that patients who accept the drug have a strong belief that disulfiram will generally help them to remain sober and will help them to resist the urge to drink (7, 8). It may be beneficial to try to convince skeptical patients that the drug can be helpful. Sources of doubt about the drug's effects and value should be identified, and misconceptions about side effects should be clarified.

CONTRAINDICATIONS—WARNINGS—PRECAUTIONS

There are several relative contraindications to the use of disulfiram. These include a history of an unusually severe reaction, a history of severe cardiovascular disease, diabetes mellitus, cirrhosis of the liver, hypothyroidism, or a psychiatric history of major affective disorder, schizophrenia, or dementia. A patient with a history of rubber contact dermatitis may be at high risk for an allergic reaction to disulfiram. Pregnancy should be considered a contraindication.

Table 6A.4.
Drug Interactions with Disulfiram

Interacting Drug	Effect
Coffee	Decreased clearance; possible increased stimulation
Ethanol-containing beverages, foods, products	Disulfiram-ethanol reaction (Table 6A.1)
Isoniazid	Decreased clearance; exaggerated effects
Benzodiazepines	Decreased clearance; increased sedation
Warfarin	Decreased clearance; enhanced hypoprothrombinemic effects possible
Phenytoin	Decreased clearance; possible toxicity
Cyclic antidepressants	Decreased clearance; increased side effect risk
Metronidazole	Possible precipitation of acute toxic reaction
Marijuana	Synergistic central nervous stimulation?

Table 6A.5.
Expected Side Effects from Disulfiram Therapy

Effect	Rare	Less Common	More Common
Dry mouth		X	
Blurred vision		X	
Nausea		X	
Vomiting		X	
Drowsiness			X
Dizziness			X
Ataxia		X	
Headache			X
Restlessness			X
Excitement			X
Skin rash		X	
Blood pressure decrease		X	
Tachycardia		X	
Jaundice	X		
Hepatitis	X		
Peripheral neuritis	X		

VOCATIONAL COUNSELING AND PROGRAMMING

CAREER COUNSELING WITH PERSONS WHO HAVE A SEVERE PSYCHIATRIC DISABILITY: IMPLEMENTATION FOR PRACTICE

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INTRODUCTION

Vocational assessment, career counseling and job retention strategies form the structural backbone of vocational rehabilitation programming for persons with severe psychiatric disabilities. Underlying this conceptual framework are five basic premises: Slide 1

(1) Traditionally, persons with severe psychiatric disabilities have failed to access or benefit from vocational rehabilitation services without a bridge between mental health and vocational rehabilitation resources.

(2) The process of career decision making and work readiness is dependent upon a developmental process which involves the clients' sense of his/her own personal identity, his/her self-concept as a worker, and knowledge of the world of work. Persons with severe psychiatric disabilities by virtue of their illness have experienced major set-backs in the vocational maturation process.

(3) The existence of a helping relationship which draws upon the individual's strengths and engages him/her as a collaborator is essential to the process.

(4) The vocational rehabilitation effort can start at any point in the individual's "career as a patient"

depending upon the individual's desires, needs, and level of adjustment.

(5) Any effective treatment or rehabilitation program or model must be based on an individualized, comprehensive assessment.

In order to effectuate the vocational process a range of options is required. Among these options are the provision of career counseling services which include the use of vocational interest and aptitude measurements, job seeking skills training, work adjustment counseling, and rehabilitation counseling. Slide

Job seeking skills training, conducted on an individual or group basis, prepares individuals to be able to thoroughly complete applications, generate job leads, prepare resumes, organize employment searches, and present themselves well in employment interviews. Attention is specifically paid to handling interview questions regarding disrupted work histories, frequent job changes, or medical status.

Inability to maintain employment, in many cases, is related to impaired interpersonal skills or inability to cope with pressures of employment. Work adjustment counseling includes training in social and/or coping skills with an emphasis upon adapting to stressors in the work environment. Work adjustment counseling also involves analysis of job performance problems and strategies for remediation. Supportive counseling and long term supportive services are most often necessary for individuals who are apprehensive regarding the transition to employed status after previously having had minimal or unsuccessful employment experiences.

Not all persons with severe psychiatric disabilities, however, will have the ability to pursue vocational or educational goals. Nonetheless, they often present a need to involve themselves in gradual, structured activities in order to improve functional abilities. Sometimes, rehabilitation counseling is a prelude for vocational planning. In other cases, vocational planning functions solely to improve the quality of daily life. Very frequently, this service is appropriate for those persons with chronic, recurrent illness histories or those recently discharged after a psychiatric hospitalization.

In any case, prior to the provision of job seeking skills training or work adjustment counseling, for the vast majority of individuals with debilitating psychiatric disorders the need exists for vocational and career counseling services. Most such persons have had significant difficulty in identifying and implementing realistic vocational/educational plans, and counseling services must be geared toward formulating feasible goals which are compatible with their particular interests, abilities, and tolerance for stress. Vocational/career counseling in this context will differ from traditional career counseling models because greater attention must be paid to the individual's concerns and anxieties about the future and the prospect of increasingly independent functioning. However, in order to modify a process of career counseling to meet the unique needs of this particular group of persons with major psychiatric disabilities, it is necessary to understand the theory behind career and vocational counseling in general.

CAREER COUNSELING THEORY

Career counseling has been defined by Super (1984) among others as a process of helping individuals to develop an integrated and accurate understanding of themselves and the role(s) they may assume in the world of work, to test these understandings against reality, and to convert them into reality in a manner which is satisfying to the individual and to the society in which he/she functions. Inherent in this definition are the notions of self-concept (identity), the realities of the work world, and the implementation of a career plan. The process goes beyond merely deciding upon a career

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choice and is dependent upon, among other things, the inherent talents and special abilities which an individual possesses, the instrumental and associative learning experiences from which a sense of self derives, and the environmental opportunities which exist for any given individual.

A number of theories have been articulated to explain the process of career choice and career development, and among the most widely known are the theories of Holland (1959), Mitchell and Krumboltz (1984), Roe (1957), Super (1953). Across all theories but to a varying degree, the issues of critical periods and agents, interests, needs, aptitudes, and the role of the family are dealt with as either determinants of or contributory factors to the career development process. Problems which emerge in this process have been linked to four main factors: (1) the likelihood of a retarded rate of development in general which causes an individual to fail to have the skills necessary to cope with the educational development tasks relevant to his/her age and position level; (2) inadeqaute emotional adjustment; (3) inaccurate self-evaluation; and (4) frozen behavior between two attractive behavior sequences (Osipow, 1973).

Slide

Krumboltz (1983) has further defined a series of specific problems which may arise in the process of career choice and vocational development because of dysfunctional or inaccurate world views and self-observation generalizations. These include the fact that persons may fail to recognize that a remediable problem exists and have adopted the attitude, instead, of "that's the way things are". Second, persons may fail to exert the effort needed to make a decision or solve a problem, preferring the path of least resistance or avoidance altogether. Third, individuals may eliminate a potentially satisfying alternative for inappropriate reasons based on misinformation, overgeneralizations, or false assumptions. Fourth, individuals may choose poor alternatives for inappropriate reasons (parental pressure, issues of prestige, fear of failure). And fifth, persons may suffer anguish and anxiety over their perceived inability to achieve their goals (if I can't be the best, why bother). Finally, Krumboltz identified several processes which may underlie the development of these problematic self-observations and world-view generalizations, including the drawing of faulty generalizations, making comparisons with a single standard, exaggerating the estimate of the emotional

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impact of the outcome, drawing false causal relationships, being ignorant of relevant facts, and giving undue weight to low probability events.

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These potential problem areas and distorted self-observations and world view generalizations are extremely potent issues when we address the career development and eventual vocational adjustment of individuals who are disabled by virtue of severe and chronic mental disorders. The reasons for this are several and include such factors as learned helplessness, low self esteem resulting from repeated failures, the unpredictable nature of the illness and the resultant sense of lack of control, environmentally-based disincentives, the nature of the individual's anxiety, and his/her tolerance for stress. Anthony, Howell, and Danley (1984) addressed these concerns when they wrote regarding the vocational counseling process with persons who have psychiatric disabilities:

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> More time is needed to go through the process because of the client's vocational immaturity. More energy is needed to form a collaborative relationship with clients who are used to having things done to and for them rather than with them. More strategies are needed to allow clients

> opportunity for reality testing and exploration. More strategies are needed for dealing with stigma against the psychiatrically disabled client. More effort must be devoted to the deliberate refocusing of the helping process on the client's needed skills and environmental supports rather than focusing on client pathology (p. 233).

It is the unique nature of the career counseling process with individuals who are severely psychiatrically disabled which will now be addressed.

VOCATIONAL IMMATURITY

The work of Super (1964, 1969, 1972, 1981) as well as Ginzberg, Ginsberg, Axelrad, and Herma (1951) speaks to the issue of vocational choice from the perspective of developmental periods. These periods can span some fifteen years, beginning typically when the child is between the ages of ten and twelve (Fantasy period) to a Tentative or Exploratory period between the ages of 12 and 17 or 18, and to the Realistic period or Establishment phase between the ages of 18 and 24. During these periods specific developmental tasks with respect to a vocational self-concept need to be accomplished. For example, during the Tentative period (Super's Exploratory phase) the adolescent moves away from the arbitrary selection of occupational preferences

Slide

and comes to recognize what particular skills he/she may possess, what he/she likes and dislikes, and what values, both intrinsic and extrinsic, may be held. During the Establishment phase, or Realistic period, which Super equates with young adulthood, the individual is engaged in a series of vocational developmental tasks which include formulating ideas about types of work which are deemed to be appropriate, specifying a vocational preference, and implementing a vocational plan. Between the ages of 25 and 35 the individual is settling down within a field of work and using individual talents to demonstrate the appropriateness of career decisions previously made. Finally, between the late 30's and mid 40's the individual seeks to establish him or herself in a given career in terms of well defined skills and seniority. Osipow (1973) comments "(t)he degree to which the individual accomplishes these vocational tasks is a function of the adequacy with which he/she has performed the behaviors appropriate to each phase of his/her development" (p.140). The rate and level of an individual's development with respect to career issues is known as vocational maturity.

Persons who have severe and persistent mental illness are generally beset with the disease process in late adolescence and early adulthood. Those years spent by their non-disabled peers in the Tentative and Realistic periods are spent by these individuals in and out of psychiatric hospitals with concomitant disruptions in their educational, social and vocational endeavors. So that when we speak of vocational readiness in the context of career counseling with persons with psychiatric disabilities, we must ascertain the level of development which any given individual may have attained. The person who aspires to become an opera star, a concert pianist, or a physician, may still be in the Fantasy period. On the other hand, he/she may have experienced an interruption in the process of beginning to pursue a career in one of these areas. To make assumptions initially regarding the unrealistic quality of a particular individual's career aspirations without understanding his or her level of vocational maturity is an error to be avoided. Understanding the individual's vocational self-concept and judging the level of vocational maturity can only be accomplished through an ongoing assessment process which then enables the practitioner to facilitate appropriate opportunities for growth, exploration, risk-taking, and reality testing.

THE COLLABORATIVE RELATIONSHIP

It is vital to the process of career counseling with persons who have severe and disabling mental disorders to establish an ongoing collaborative relationship with them. This diminishes the likelihood that the individual will slide back automatically into the "sick patient role," while at the same time reinforces the individual's capabilities through healthy expectations. It is important for the client to understand that the ultimate responsibility for career choice cannot rest with the practitioner. This does not mean that the professional helper takes an inactive role and merely reflects the client's feelings, but rather that the counseling relationship should be one in which both individuals collaborate to resolve the problem of career choice.

A holistic view of the person with a severe psychiatric disability is a sine qua non of this approach. This holistic view is predicated on the following principles. Slide 1

- The practitioner and the primary consumer are educated about the nature of the particular mental illness which is causing the disability. Slide 1

- The practitioner and the primary consumer are educated with respect to the psychopharmacologic management of the particular illness involved.

- Time is needed in order to achieve a level of vocational maturity that persons without serious mental illness have had the opportunity to develop over a period of 15 years on the average.

- Individuals with severe and persistent mental illness must come to recognize their strengths and believe in their capabilities so that fears of failure and success can be overcome.

- Both the practitioner and the primary consumer must be knowledgeable about and able to "use" the system.

- The process of psychiatric rehabilitation and successful vocational outcome is highly dependent upon collaboration between consumer and service provider and among service providers themselves.

Integral to the process of establishing this collaborative relationship between the practitioner and the primary consumer are issues of content and process. The counselor/practitioner working with an individual with a psychiatric disability cannot rely solely on a superficial exploration of his/her problems regarding the choosing of a career or vocational objective. At

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the same time, the professional helper must refrain from straying so far from career issues that the efforts of the individual's primary therapist are duplicated. For example, if a client has a very poor self-image and disregards his or her assets, these problems can appropriately be addressed under the framework of career counseling. The counselor would not want to focus on these issues exclusively, rather he or she would want to clarify how these problems may have interfered with the client's career aspirations or plans in the past and how the situation might be altered in terms of future planning. Often, the counselor will work on more than one agenda with a client simultaneously. While there may be didactic teaching concerning the career choice process or how a systematic career decision is made, at the same time efforts are directed at addressing related and significant personal and interpersonal issues. For it has now been well established that for persons with psychiatric disabilities, problems on the job and job retention most often relate to personal and dysfunctional interpersonal behavior rather than lack of skills or competency.

INTERVIEWING

A significant part of the work of the practitioner who is engaged in career counseling will take the form of interviewing, particularly at the outset of the process. Interviewing clients with psychiatric disabilities on issues related to vocational rehabilitation can be difficult for a number of reasons. Work identity and self-esteem are often so interwoven that vocational issues become personally threatening or sensitive topics. In addition, the client's symptomatology can make communication on these sensitive issues even more difficult. There are some aspects of the interviewing process which seem to pose particular problems for both experienced and less experienced counselors. The focus of the following discussion will be on the initial series of client interviews because of the role they play in the future course of counseling. Many of these guidelines, however, are applicable to the management of subsequent counseling sessions as well.

The initial interviews are of particular importance for a number of reasons. Quite often they comprise a setting in which clients will be most candid and less prone to conceal information which is painful, but important to discuss. These early interviews are also of special significance because they represent the point in time in which roles are assumed within the therapeutic relationship and assumptions are made which affect the future course of counseling.

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Accuracy of perception is critical during these initial meetings because both counselor and client tend to make a series of important judgments during this period. The counselor/practitioner often views the manner in which the client presents him or herself as a sample of that individual's behavior and attitudes. Judgments are made which often include inferences about the client's suitability for rehabilitation and services which might be appropriate. The client makes judgments which often include deciding whether or not further involvement with the counselor and rehabilitation will be beneficial. Thus, it is very important that both the counselor and the client perceive each other as accurately as possible during these initial encounters.

Behavior, in general, tends to be situation specific. The manner in which individuals present themselves during these early meetings, therefore, will be influenced by their understanding of the context in which they find themselves. The following guidelines may serve to maximize the likelihood that individuals with psychiatric disabilities will present themselves in a relatively straightforward manner during these initial sessions. These include (1) clarifying the basic purpose of the interview (2) eliciting the individual's feelings about his/her participation in the interviewing

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process (3) discussing and alleviating concerns that the practitioner has a role (unless there is one) in determining eligibility for financial assistance and other types of benefit programs, and (4) encouraging questions throughout the interview. If the client understands the purpose of the interview and if conern about "hidden agendas" is alleviated, he or she will be less likely to skew the manner in which information is presented, and the practitioner will get a much more accurate picture of the situation. Furthermore, as anxiety about the interview is diminished, the client may present him or herself in a more organized fashion.

Errors in Perception. It is also important to accept the fact that the initial impression formulated by the professional about the individual seeking services may be distorted. For example, upon initially meeting a client whose dress and grooming is very poor, it is easy for the counselor/practitioner to begin to build a model of what he or she thinks this individual might be like. This quite often includes the automatic and global assumption that he or she has poor rehabilitation potential. What could be more accurately assumed is that deficits in dress and grooming need to be addressed in order to maximize rehabilitation potential. Conversely, such prototypic thinking can

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lead to overestimating the abilities of well-dressed, attractive clients.

When errors are made in perception, they often involve a lack of attention to the context of events. Client and counselor expectations are part of this context. The manner in which a client presents him or herself to the counselor may be related to negative expectations. For example, if the individual with a severe mental disorder fears that the practitioner will pressure him or her into employment, then he or she may be careful to maximize his or her deficits.

Similarly, judgments about clients are affected also by the practitioner's own expectations, as well as his/her previous experience in psychiatric rehabilitation. It is fair to say that, despite the rewards of working in this field, practitioners repeatedly encounter many disheartening situations. The experienced practitioner has seen that in psychiatric rehabilitation the treatment outcome is often less than ideal. Most have become familiar with the revolving door syndrome of repeated psychiatric episodes and have been exposed to highly frustrating experiences in working with clients who have chronic and severe psychiatric disabilities. The counselor works very hard with a client, sees improvement, only to find out that the individual has decided to terminate his or her medication which results in relapse and the onset of acute psychiatric symptomatology. Moreover, the seasoned rehabilitation practitioner has experienced the very somber reality that a client can make substantial progress and still be unable either to find or to tolerate employment. As practitioners who enter the field with some idealism, we naturally suffer disappointments throughout the years. These negative experiences can affect how we perceive clients, how we handle sessions, and, ultimately, how we judge our clients.

Communication Barriers: Symptoms and Language. In addition to the counselor's and the client's natural tendencies to misperceive matters to some extent, effective communication during the interviewing process is often hindered by client symptomatology and problems of verbal expression. A discussion of some problems related to verbal expression which may occur when interviewing persons with schizophrenia and other psychiatric disorders may prove helpful at this point. Slide 16

Often times, symptoms seen in clients having schizophrenia involve disturbances in the expression and regulation of emotion. Customary emotional responses that a counselor has learned to except in working with less disabled clients are often absent. In most social exchanges, facial expression and fluctuating voice tone can be used as signposts to help understand what the other person is feeling. When interviewing a client with a schizophrenic disorder, these markers may be absent, greatly diminished, or outright confusing. Therefore, emotional rapport may be difficult to establish.

In addition to either the lack of affect or the disconcertingly incongruent affect, the person having schizophrenia, upon interview, may present with an apparent lack of interest in discussing rehabilitation issues. If the individual does engage in conversation, his or her thoughts and verbalizations may be poorly organized and, at times, irrelevant. This disorganization is sometimes most prominent in the earlier segments of an interview when anxiety is highest. It also becomes more problematic if the client becomes fatigued towards the end of a lengthy session.

There may be problems with the symbolic aspect of language as well. This is seen with clients who have a tendency to employ obtuse verbalizations or overly concrete responses. Misinterpretations and difficulty in understanding caused by vagueness of presentation can be experienced by both the counselor and the client.

Difficulties in establishing effective communication result in some very natural feelings which do affect counseling. The practitioner may feel diminshed empathy as a consequence of the client's lack of affect and reluctance to express his or her concerns. If the client presents as detached or unmotivated, the counselor may feel subtly rejected or unappreciated, further inhibiting emphathetic responses. Continued introduction by the client of material which is unrelated to the situation can result in a range of counselor reactions, from frustration to boredom. Feelings of discouragement with respect to the feasibility of rehabilitation with the client may develop. The client's confused speech may lead the counselor to assume the client does not know what he or she wants. This may pose yet another threat to the pursuit of accurate understanding and the development of rapport. Furthermore, strange or bizarre verbalizations can be disturbing to the clinician, and this may result in distancing which is often readily sensed by the client.

Interviewing Techniques. Guidelines which may be helpful when interviewing clients having schizophrenia include (1) helping the client organize his or her thoughts; (2) when the client is tangential, helping

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him or her return to the central point; (3) providing sufficient time for the client to respond to questions without prolonging the silence; (4) adjusting the length of sessions; (5) remembering that confused verbalizations do not always mean that the client does not have a meaningful opinion; and (6) not getting caught up in debating delusional material. Slide 18

Helping the client organize his or her thoughts may take the form of paraphrasing the client's statements and then asking if the counselor has understood the point correctly. This is done while conveying that the counselor does not want to put words into the client's mouth. Helping the client return to the central point can be accomplished by making statements such as, "A moment ago we were talking about . . , and you were telling me that . . . Let's go back to . . ."

While it important to provide adequate response time, the client may have a delayed response pattern because of his/her cognitive or articulatory impairment. Therefore, it is best not to prolong silence to the extent that the client becomes embarassed over difficulties in responding. Moreover, there may be a need to adjust the length of the session. Some clients need some time to "get warmed up"; others fatigue as time progresses and then have more difficulty organizing their thoughts.

Confused verbalizations do not in and of themselves indicate a lack of meaningful opinions. Practitioner skill in handling this problem probably differentiates those who work well with persons having schizophrenia from those who do not. And finally, delusional material can not be debated. Debates over delusional material can result in delusional beliefs that become even more entranched. As trust develops over time, the counselor might suggest alternative perspectives on how the client could interpret events. A frontal attack on delusions, however, is not productive. One can "agree to disagree" on some issues where appropriate. This enables attention to be turned toward issues which are germaine to the vocational goal at hand. It is also important to bear in mind, however, that some delusional clients can work or attend school. While it is certainly desirable for these symptoms to abate in order for the process of career planning and career implementation to progress, it is not always necessary.

Interviewing individuals with manic symptoms can pose a different set of problems. Instead of a paucity of speech, which one often encounters with the person who has a thought disorder, there is often verbosity. Slide 1

The individual speaks very rapidly in a pressured manner with a great deal of detail, wandering from topic to topic. Counselor reactions may include the feeling of "losing control over a session". This may result in anger, especially if the practitioner feels pressured to complete a specific agenda. When interviewing clients with manic symptoms, the professional helper should provide increased structure. Do not hesitate to interrupt, but do it in a spirit of interest in what the client is saying. Guidelines are actually similar to those used to compensate for the disorganization which can occur when interviewing clients who have a schizophrenic disorder. If necessary, the practitioner may want to slow down his or her own speech. This may result in a reciprocal slowing of the client's speech which can help the counselor not to feel bombarded. Asking the client to speak more slowly is quite straightforward, but it is sometimes neglected.

Many illnesses, like schizophrenia, are thought to derive from a biochemical imbalance. And, often the resultant symptoms cannot be entirely controlled. It is important to bear in mind that these symptoms can function to influence and/or control what occurs in the counseling relationship. This takes place either through the counselor's reactions to the symptoms or the client's use of these symptoms to avoid discussion of issues which are relevant but potentially painful. The client may use symptoms to distance the practitioner if he or she feels the threat of too much intimacy. This does not necessarily mean that these symptoms have a psychodynamic base, but rather that clients learn the impact their symptoms can have on others. Quite reasonably, then, they will sometimes use symptoms to control relationships when they feel threatened.

Finally, it is within these early meetings that the interpersonal relationship between client and practitioner begins to be defined. Quite often the individual seeking services wants to place the helper into a role(s) which replicates that of family members or significant others. Typically the assumption of these roles by the counselor is not in the client's best interest. Awareness of this issue can often emerge early in the counselor-counselee relationship, and the counselor must be cautious about sliding into such roles inadvertantly.

In a similar vein, some practitioners assume that a client will "fall apart" if provided with direct feedback regarding his or her interactions with others. Typically, these fears are unfounded; nonetheless, clinicians may censor their reactions. The result of this is usually unsuccessful as feelings can often color both verbal and nonverbal behavior, whether they are expressed or not. Most importantly, the client is deprived of accurate feedback which is essential if he or she is to learn how to develop reciprocal, positive relationships with others. The very aspects of a client's behavior which the practitioner finds obnoxious, but which he or she refrains from addressing, are those behaviors that most likely will harm the client's relationships with others. In particular, relationships on the job, in school, or in work settings with co-workers and supervisors, may suffer. These relationship issues will become a focus of the career counseling process as the vocational rehabilitation process unfolds and the ultimate goal is achieved.

STRATEGIES IN THE CAREER COUNSELING PROCESS

One way to better understand the process of career counseling is to view it as a series of stages Crites (1981). While stages have been delineated for ease of understanding, it is recognized that career counseling is a more fluid and dynamic process. Moreover, although the first stage describes a focus for the helping person, this does not mean that he/she dominates the process. Rather, the practitioner structures the sessions in order to obtain an understanding of the client and his or her perceptions, attitudes, and concerns. It is important to recognize the connection between the practitioner's role and that of the client in order to understand the therapeutic aspects of career counseling. The following discussion adapts the work of Crites to the process of working with individuals with major psychiatric disorders.

CLARIFICATION AND INFORMAL ASSESSMENT

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The first stage in the career counseling process involves a series of steps or strategies aimed at (1) clarifying the individual's concerns and perceptives on his/her problem (2) determining the individual's expectations of the career counseling and vocational readiness process (3) understanding the individual's perceptions with respect to his/her previous educational and/or occupational experiences and (4) helping the individual to reformulate his or her conerns through an awareness of those factors which have contributed to the present dilemma, which problems can be resolved, and how to begin to utilize a decision-making (problem-solving) approach in those areas where remediation is possible.

Clarification of the problem. An understanding of the individuals perception of problems related to the career/counseling process is essential. How does he/she describe current needs, conflicts, and difficulties? Can the individual articulate problems regarding the choice of what he/she might like to do in the occupational arena? Does the individual verbalize the ideas and values of others--the therapist, a parent, a spouse? Often the well meaning counselor assumes to know what the client may need and proceeds to act accordingly. In this case career counseling will be ineffective or the client will terminate the process before the counselor's goals are achieved.

DIANE I

Eliciting the client's perspective on the problem of career choice is important for several reasons. First, clients often have good insight and may be aware of what processes will facilitate problem resolution, e.g. what has worked for them in the past in other circumstances. Second, it is important to understand the client's frame of reference and his or her manner of viewing the specific situation and life in general, even if the counselor objectively feels the client lacks insight. For example, a client may project his or her career failures onto others, an unsupportive parent, a teacher who actively disliked him or her, a counselor who gave bad advice, etc. Even though there may be background information available which suggests that these perceptions are not accurate, the counselor will need to understand how and why the client views the situation as he or she does, or the counselor will never connect with the client. Asking the client about his or her assessment of the problem serves an additional positive function within the counseling relationship. It indicates an interest in understanding the client, demonstrates that his or her opinions on the issues are valuable, and helps in establishing the collaborative relationship early on.

PATRICK

Expectation of treatment or rehabilitation. Here the concern is with the outcome(s) the client desires. What are the specific educational or vocational goals that the client wishes to achieve in order to resolve his or her current dilemmas? Often the client comes to the counseling session and states, "They told me you'd get me a job." We are thus reminded of Anthony et al. (1984) earlier comments regarding "clients who are used to having things done to and for them rather than with them". Expectations here are based on what the client has come to believe is a way of life, following directions, passively accepting advice and counsel, having had little or no opportunity to develop personal career aspirations. Personal ownership of goals is a foreign and unfamiliar concept.

At other times the individual with a major psychiatric disorder has only a vague notion of what he or she would like to achieve. In the words of one client, "to go to school and get a good job." Expectations are of the norm and what is socially appropriate, but with no real specificity. For these individuals coming to recognize that the career counseling process can assist with this noble but overwhelming goal is a legitimate end in and of itself.

Perceptions of previous work or educational experiences. A review of the individual's educational and vocational history as well as his or her current activities constitutes a semi-structured but informal assessment strategy. Such a process helps the client and the counselor to gain a common perspective on the problem through an exploration of the client's educational and vocational experiences, undertaken in a chronological sequence. This process helps the practitioner/counselor begin to get an understanding of the client's assets, limitations, interests, and experience.

If the client has a work history, it is important to review each job to find out what aspects he or she liked or handled well, as well as what aspects were not as positive. The reasons why the client left each educational or employment endeavor should be explored. The nature and quality of relationships with peers, coworkers, and supervisory staff is also important to understand.

This longitudinal view of the individual's educational and/or work experiences often provides the practitioner with a more objective basis for understanding a particular individual's vocational problem and for identifying his or her strengths. It also may help the client become more aware of patterns in his or her vocational history. For example, the client may feel he or she has failed in most endeavors, but may alter that perspective when reviewing the actual history in greater depth. Or, a client may learn that he or she has never really taken responsibility for career choices, but instead has relied only on the guidance of friends and family and has found him or herself in occupations for which he or she was not well suited.

Reformulating concerns and identifying resolvable issues. Only after a climate of trust and rapport have been established can the practitioner begin to help the individual client recognize and deal with issues and concerns that have come to the surface during the early part of the Clarification and Informal Assessment stage.

Harry Stack Sullivan (Perry & Gawel, 1970) underscored the importance of a client getting something back for what is given in the interview. This should occur even in the initial sessions when information is gathered. Initial impressions of the factors involved in the client's specific career problems should be shared, yet qualified as initial impressions. Along with this tentative formulation, the counselor will want to speak of strategies that can be used in future sessions. This procedure provides a much needed sense of "hope" while at the same time helping the client to begin to learn about systematic career decision-making. Frequently, as counseling progresses, issues related to self-concept or personal skills become more prominent, and it becomes apparent that these have an important bearing on the career choice problem. The career problem may than be reformulated to reflect these dimensions.

In assisting clients to alter dysfunctional or inaccurate beliefs, self observations and world view generalizations (Mitchell & Krumboltz, 1984), practitioners need to be sensitive to why individuals may be resistant to altering, changing or even revealing them, even if alternative beliefs may be more adaptive. Mitchell & Krumboltz go on to explain that society reinforces individuals who give socially acceptable reasons for their behavior and punishes those who engage in the same behavior for unacceptable reasons. Also, many individuals have extreme fears about the consequence of examining important beliefs. With these cautions in mind, the counselor, but only after trust and rapport exist, (1) can examine the assumptions and presuppositions underlying expressed beliefs ("I'm too stupid to go to school . . . I've only ever been fired from my previous jobs . . . My parents will never understand . . . I'll be happier if I sit in my apartment alone all day . . .") (2) can look for inconsistencies between words and actions, and (3) then can identify specific barriers to the vocational or educational goal with which the individual can relate.

Finally, Mitchell and Krumboltz (1984) recommend the use of specific cognitive restructuring techniques to facilitate the reformulation of concerns and the identification of resolvable issues utilizing problem solving strategies. Specifically:

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(1) direct instruction about the role of cognitions in subjective stress and behavioral deficits;

(2) monitoring one's personal thought patterns;

(3) modeling of a rationalistic evaluation process and modification of personal thought patterns;

(4) feedback on reported changes in thinking patterns and behaviors; and,

(5) performance assignments and rehearsal tasks to improve discrimination and evaluation of performance-relevant cognitions.

FORMAL VOCATIONAL ASSESSMENT

Stage two in the process of career counseling with individuals who have major psychiatric disabilities involves the use of vocational interest, values, and aptitude measurement tools. Vocational assessment enables both the primary consultant and the practitioner to better understand the consumer's interests, abilities, and work environment preferences as related to various career options (Katz, Beers, Geckle, & Goldstein, 1989). Very often a client holds either a very self-depreciating or aggrandized view of his/her abilities. Vocational assessment provides a more objective method of identifying strengths and deficit areas.

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To a great extent, an individual's ability to integrate into the world of work is contingent upon the ability to formulate a realistic occupational goal. Vocational assessment procedures are instrumental in the formulation of realistic goals and can provide a profile of characteristics relevant to career decision-making. A core battery of tests is often useful in providing the kinds of information needed to help a particular individual make realistic choices about career or vocational endeavors. Such a battery frequently includes the use of interest inventories, ability measures, and inventories of the clients' values that surround the work role or work environment. Information derived from testing enables a systematic exploration of careers that might be particularly advantageous and provides information concerning fields to avoid and/or types of academic remediation that might be beneficial. Assessment provides a relatively objective base of information. This is important because individuals with long standing psychiatric illness may not have very accurate assumptions about their abilities. That is, they may overestimate or underestimate them.

The vocational assessment serves an important and natural role in career counseling, but judicious timing is necessary if the assessment is to be beneficial. If undertaken prematurely, results can be misleading. There may be an increase in the client's defensiveness and the results might undermine his or her self-esteem. There is a need to determine whether the client's symptomatology will significantly affect the information that is derived from the assessment. This is important because a vocational assessment serves as a sample of opinions and abilities. The sample must be representative because generalizations are derived from it. When individuals are in an acute phase of their psychiatric illness, testing may need to be delayed. Other individuals experience the presence of symptomatology on a fairly consistent basis. Under these circumstances, formal assessment procedures may be timely, but the impact of the symptoms must be recognized and the results interpreted accordingly. The results may provide a picture of how the individual is performing at a particular point in time but may underestimate future levels of performance. Consideration also must be paid to the client's feelings regarding formal testing procedures. The optimal time for a formal vocational assessment is when the individual presents a desire to resolve questions about future plans by learning more about his or her interests and abilities.

It is important to bear in mind that although the results of the vocational assessment can provide an important base of knowledge, the results can also be misleading. Just as clients often believe the answers to career planning lie solely in test results, practitioners may hold similar misconceptions. Test results are best understood in the context of a more general appraisal of an individual's overall functioning. Therefore, it is necessary to examine results carefully, always keeping in view the client's life circumstances and general adjustments. For example, it is misleading to identify high mental ability and not to determine whether it is available for the client's use.

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Finally, the results of a formal vocational assessment must take into account other important factors related to academic or career success. An individual's social skill repertoire, tolerance for specific stressors, and capacity to sustain goal directed behavior are highly significant. As formal vocational testing may tell us little about these factors, testing results must be interpreted cautiously unless during the earlier stages of career counseling these issues had been clarified. Thus, formal vocational testing and measurement has an important role in career counseling, but it is not the crux of it.

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CAREER EXPLORATION AND SYSTEMATIC DECISION MAKING

The major task to be undertaken during this third stage is to gather information about the world of work. The objectives of the systematic career decision process

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are not only to resolve the client's career indecision, but also to teach and model how these kinds of decisions are made. This is important because, hopefully, the client will incorporate these skills into his or her repertoire for future use. Systematic career decision-making focuses upon identifying a career which is congruent with the client's interests, abilities, values, and tolerance for stress. As part of this process, career exploration strategies are essential.

Career exploration can involve the use of resource material to learn about specific careers. The Occupational Outlook Handbook, the Dictionary of Occupational Titles, and other references which may include computerized and videotaped sources of information can prove helpful (Zunker, 1986). In addition, volunteer work might be done in a setting related to client interests; site visits, informational interviews, and shadowing are often helpful techniques as well. The desire to work in a hospital laboratory service, for example, without a direct knowledge of what kinds of job duties and responsibilities are expected of laboratory staff can be based on faulty assumptions or preconceived notions. One can read about using microscopes and other highly specialized instruments, but the actual process of experiencing the laboratory setting itself--testing body fluids, the importance of universal precautions, adherence to rigid testing procedures--can be the most valuable ingredient in the decision making process. Similarly, the process of trying to decide upon a career option that involves years of education or specialized technical training can be facilitated by encouraging the individual to pursue a single course of study in a high interest area.

This active career exploration promotes independent functioning as well as providing the client with detailed information regarding the nature and demands of specific occupations of interest. In their article describing "The Choose-Get-Keep Model" of supported employment for persons with psychiatric disabilities, Danley and Anthony (1987) make several comments which are highly pertinent to the career exploration and decision making process:

> The assumption of psychiatric vocational rehabilitation is that with increasing time and different vocational experiences, the clients' interests and values often change. Unfortunately, clients' occupational choices following the onset of the disability are oftentimes based on former values and skills rather than on a comprehensive picture of their current values and skills. It may

> in fact be desirable to create new occupational experiences, short of a supported vocational placement, to clarify interests and values. The truth is that they can when they are stimulated by new knowledge gained first hand from relevant vocational experiences (pp. 7; 28).

IMPLEMENTING THE CAREER PLAN

The counselor's task during the fourth and final stage of the career counseling process is to assist the client in developing a specific plan whose focus is the implementation of his or her career choice. This includes indentifying subgoals of manageable proportions. Subgoals are important because many clients with long term mental illness have difficulty getting started as they are so overwhelmed with the magnitude of the task in terms of time, energy, and resource commitments. Their dismay is often manifest as problems in organizing their efforts, in remaining goal focused, or in handling anxiety. Some may want to tackle much at once to make up for "lost time".

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The technique of reviewing provides an opportunity to determine whether obstacles have occurred or may occur and to plan effective interventions and means to assist the client in the transition to increased and sustained activity and social contact. Reviewing can be used also as a time for "trouble shooting". Reviewing is important throughout the process of career decision making as well as during the process of implementing a career plan. It enables the client to experience feedback, both positive and negative, and to learn to self-monitor his or her own reactions to this feedback. Self-monitoring can then be exercised "in vivo" because there has been a previous opportunity to learn how to utilize this inner resource. It is important to recognize, however, that the success of self-monitoring depends not only on the client's ability, but also upon the counselor's willingness to provide support and consensual validation when appropriate.

Motivation. When assisting a client with the implementation of his or her career plan or vocational objectives, one of the most common traps practitioners fall into involves labeling a client as unmotivated and then terminating him or her until the individual "shows more motivation." This is not to say that discontinuing the process of career planning and implementation is never indicated, but rather, that problems which involve motivational issues are part and parcel of the vocational rehabilitation process and need to understood

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accordingly. That is, motivational issues are to be expected and are most probably the norm. It is unfortunate that "resistance" and motivational problems are not acceptable in the rehabilitation setting; in more classic psychotherapy, resistance to the treatment process is acknowledged as an expected part of working toward change. Such acceptance, however, is often not seen in rehabilitation settings. Clients are rather automatically labeled as unmotivated when they fail to implement established rehabilitation plans. By labeling a client as unmotivated we act as if motivation (or lack of it) were a personality characteristic, and then this label is used to justify the withdrawal of services. We act as if we knew what the term "unmotivated" means.

Lack of motivation needs to be understood within the context of the client's frame of reference. With some exceptions, motivation is situational. If one examines the thoughts of the classic "unmotivated" client, one will find negativistic thinking, anxiety, and/or the desire to avoid further losses. This might be thought of as a fear of getting better. The bottom line is that few people are motivated to enter situations which they feel they will be poorly equipped to handle. Most people are afraid of change even when they want it. So, rather than label a client as unmotivated, counselors must identify the factors that contribute to the indivudal's avoidance of rehabilitation activities and work with him or her to resolve these concerns.

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Unrealistic Career Goals. In addition to motivation, the other commonly seen problem in the process of implementing a career plan is that of unrealistic career goals. Unrealistic career aspirations may be related to symptoms; for example, a patient having a bipolar disorder may be grandiose. Second, unrealistic career aspirations might be related to the given environment in which the client has had a long-standing "career", i.e., wanting to be a psychiatrist or a social worker. The client expresses a desire to model these persons because he or she has spent the majority of his or her adult years involved with them on a variety of levels.

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Third, unrealistic career aspirations may be related to sustaining fantasies. When a client is very dissatisfied with him or herself, perhaps due to an awareness of his or her limitations, fantasy life is likely to increase. There may be an escape into daydreams about being an accomplished, highly regarded person. While these fantasies bring comfort, they also prevent the client from being able to implement a viable career plan. A realistic career plan could result in positive benefits such as improved self-esteem, financial independence, or less need to withdraw and fantasize. Although it is important not to encourage a client to pursue an overly demanding career endeavor, it is equally important not to destroy precipitously a client's sustaining fantasy because the fantasy serves a protective function. The counselor needs to refrain from striving for realism at "any cost" and simultaneously, to avoid colluding with the patient's hiding from reality.

A gradual approach toward facilitating realism of career choice is best. Often, entry level positions or limited training programs related to the highly valued career can be recommended without removing the possibility of further career advancement in the future. It is essential never to discourage abruptly a highly valued career plan. It is far easier for a client to relinquish a valued but unrealistic goal if viable alternatives are presented.

Finally, it is frequently the case that discussion of the values and influences which have led an individual to have very strong feelings about a particular career can help free the client from the consuming pursuit of an unrealistic goal. Sometimes such exploration reveals that a client is aspiring to an untenable career plan because of factors in his or her relationship with family members, i.e., excessive competition with a sibling or expectations of a parent who cannot accept the client's disability. These problems often lend themselves to group treatment providing the group is structured to promote candidness.

CAREER COUNSELING WITH WOMEN AND OTHER MINORITY GROUPS

As a final concern we would be remiss in our discussion of vocational and career counseling issues with persons who have major psychiatric disorders if we did not give special recognition to the career development problems which are unique to women and ethnic minorities among this larger population. While these concerns demand equal time, we can only refer the reader to a number of excellent reviews on the topic of women and ethnic minorities and the career development process Gottfredson (1978); Fox and Hesse-Biber (1984); Leony (1985); Orum (1986); Matthews and Rodin (1989); Ogbu (1989);Scarr, Phillips, and McCartney (1989), briefly summarize the major concerns which have an impact on persons with psychiatric disabilities, who are also members of these traditional minority groups.

Women. First, while there have been long held assumptions that the primary roles of women were those of housewife and mother and that the theories and concepts of career development used to describe and explain males would generalize to women, this is no longer the case. Women whose adult lives will not include work outside of the home have become the minority. Sex differences have been demonstrated to account for the restricted range of occupational alternatives available to women and the fact that women are socialized to pursue stereotypically female traditional occupational roles regardless of their capacities and talents. Moreover, women's career development has always involved one more step than that of men. Before a woman can decide on a career choice, she must sequentially decide whether or not to make outside employment a focus of her life Fitzgerald and Betz (1983).

Women with major psychiatric disorders face these same issues as they aspire to achieve a career or vocational objective just as all women with disabilities appear to do Slappo and Katz (1989) There must be a particular sensitivity on the part of the practitioner to these women who in many instances have failed to achieve an internalization of a self-concept which acknowledges the right to choose between equally or not so equally attractive alternatives. They also may face the process of career decision making or vocational goal achievement as single parents or caretakers of elderly parents. These additional responsibilities are affecting more and more women in society at the present time and will continue to do so in the future. Women with major psychiatric disorders are not immune to the same stressors which face their non disabled peers.

Ethnic and Racial Minorities. Second, there has developed an increased interest in the career aspirations and adjustment of racial and ethnic minority citizens in this country. This recent interest is due in large part to the uneven distribution of races and sexes in the labor market, the high unemployment rate of minority adults and minority youth, and since 1975 the creation of an "underclass" among Afro-american, Hispanic, and American Indian communities on account of a continued state of economic crisis Smith (1983). Of concern also is the increasing growth of ethnic minorities with disabilities who enter into the vocational rehabilitation system Wright and Emener (1989).

These authors and others have addressed issues surrounding career decision making and vocational opportunities which are specific to an identified ethnic or racial minority group. Therefore, we will only make several salient comments, which again relate to the career counseling process with persons who also have major psychiatric disorders. It is important, first of all, to appreciate the cultural relativity of the notion of the centrality of work in the lives of all people (MOW International Research Team, 1981). This is a tradition of Western-European culture in particular (Katz & Feroz, In Press) for American Indians work is necessary only to provide enough money to get through the day or the week, to meet the necessities of life. It's value is greatly diminished in the presence of the concern with oneness with nature. For Polynesian-Americans work can come and go, but it is the stability of the family which takes preeminence in the value system of the culture and, therefore, dictates the meaning which work as a career shall ultimately have.

Second, the concept of the dignity of all work is highly questionable since we can no longer pretend that a free and open labor market exists. We must appreciate the need for certain individuals of ethnic and/or racial minority status to separate their personal self-concept from that of their work self-concept. The practitioner is faced, then, with the problematic nature of determining what is meant by career or vocational maturity in the context of these several and diverse cultural populations and what role career counseling will or will not have. Decision making will, of necessity, need to be based on individual client values rather than on the pre-determined values of the practitioner who, more often than not, is a product of the mainstream culture. The dilemmas created by these disparate value systems are real and must be addressed as ethnic and minority groups are the fastest growing population within the United States today.

CONCLUSION

An attempt was made to address those salient aspects of the career counseling process with persons who have a severe psychiatric disability and how adaptations to the traditional practice of career and vocational counseling might be implemented. Specific concerns discussed were those of (1) the concept of vocational maturity and the developmental stages wherein the self-concept of worker emerges; (2) the nature of and necessity for a collaborative relationship between the practitioner and the primary consumer; (3) stages in the career counseling process; (4) the role of formal vocational measurement; (5) aspects of the interviewing process in light of particular symptoms and communication barriers; (6) the implementation of a career plan and the impact of motivation and unrealistic career goals on the plan; and finally (7) special concerns which arise with women and ethnic and racial minority groups in the career counseling process.

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FIVE BASIC PREMISES

1. NEED FOR A BRIDGE BETWEEN MH AND VR RESOURCES
2. VOCATIONAL READINESS IS DEPENDENT UPON A DEVELOPMENTAL PROCESS
3. NEED FOR A HELPING RELATIONSHIP
4. VR TIMING IS AN INDIVIDUALIZED PROCESS
5. NEED FOR INDIVIDUALIZED, COMPREHENSIVE ASSESSMENT

RANGE OF OPTIONS

- CAREER COUNSELING INCLUDING VOCATIONAL INTEREST AND APTITUDE MEASUREMENT
- JOB SEEKING SKILLS
- WORK ADJUSTMENT COUNSELING
- REHABILITATION COUNSELING

CAREER COUNSELING

CAREER COUNSELING IS:

> A PROCESS OF HELPING INDIVIDUALS TO DEVELOP AN INTEGRATED AND ADEQUATE UNDERSTANDING OF THEMSELVES AND THE ROLES THEY MAY ASSUME IN THE WORLD OF WORK, TO TEST THESE UNDERSTANDINGS AGAINST REALITY, AND TO CONVERT THEM INTO REALITY IN A MANNER WHICH IS SATISFYING TO THE INDIVIDUAL AND SOCIETY IN WHICH HE/SHE FUNCTIONS.

- KNOWLEDGE ABOUT ONESELF
- KNOWLEDGE ABOUT CAREERS
- KNOWLEDGE ABOUT HOW TO MAKE A SYSTEMATIC CAREER DECISION

- RETARDED RATE OF DEVELOPMENT IN GENERAL
- INADEQUATE EMOTIONAL ADJUSTMENT
- INACCURATE SELF-EVALUATION
- FROZEN BEHAVIOR BETWEEN TWO ATTRACTIVE BEHAVIOR SEQUENCES

- FAILURE TO RECOGNIZE A REMEDIABLE PROBLEM EXISTS
- ELIMINATING A POTENTIALLY SATISFYING ALTERNATIVE FOR INAPPROPRIATE REASONS
- CHOOSING POOR ALTERNATIVES FOR INAPPROPRIATE REASONS
- SUFFERING ANGUISH AND ANXIETY OVER PERCEIVED INABILITY TO ACHIEVE GOALS

DISTORTED SELF-OBSERVATIONS AND WORLD VIEW GENERALIZATIONS

- LEARNED HELPLESSNESS
- LOW SELF ESTEEM
- UNPREDICTABLE NATURE OF THE ILLNESS
- ENVIRONMENTALLY-BASED DISINCENTIIVES
- NATURE OF THE ANXIETY
- TOLERANCE FOR STRESS

More time is needed to go through the process, because of the clients' vocational immaturity. More energy is needed for a collaborative relationship with clients who are used to having things done to and for them rather than with them. More alternative vocational environments are needed to allow clients opportunity for reality testing and exploration. More strategies are needed for dealing with stigma against the psychiatrically disabled clients. More effort must be devoted to a deliberate refocusing of the helping process on the client's needed skills and environmental supports rather than focusing on client pathology.

Anthony, Howell & Danley (1983)

DEVELOPMENTAL PERIODS

FANTASY

EXPLORATORY/TENTATIVE

REALISTIC/ESTABLISHMENT

COLLABORATIVE RELATIONSHIP BASED ON HOLISTIC VIEW OF THE PERSON

- EDUCATED ABOUT THE NATURE OF THE PARTICULAR MENTAL ILLNESS
- EDUCATED WITH RESPECT TO THE PSYCHOPHARMACOLOGIC MANAGEMENT OF THE PARTICULAR ILLNESS
- TIME TO ACHIEVE A LEVEL OF VOCATIONAL MATURITY
- RECOGNIZE STRENGTHS AND BELIEVE IN CAPABILITIES
- KNOWLEDGEABLE ABOUT AND ABLE TO "USE" THE SYSTEM.

PROCESS/CONTENT ISSUES

- SUPERFICIAL EXPLORATION OFTEN UNSATISFACTORY
- NEED TO WORK ON MORE THAN ONE AGENDA SIMULTANEOUSLY

CHARACTERISTICS OF THE INITIAL INTERVIEW

1. LEVEL OF CANDIDNESS
2. ASSUMPTION OF ROLES
3. JUDGMENTS ABOUT BEHAVIOR

1. CAREFULLY CLARIFY THE BASIC PURPOSE OF THE INTERVIEW.
2. ELICIT CLIENT'S FEELINGS ABOUT THE REFERRAL.
3. DISCUSS AND ALLEVIATE CONCERN THAT YOU HAVE A ROLE (UNLESS YOU DO) IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE.
4. ENCOURAGE QUESTIONS THROUGHOUT THE INTERVIEW.

ERRORS IN PERCEPTION

- AUTOMATIC AND/OR GLOBAL ASSUMPTIONS
- RELEVANCE OF EXPECTATIONS

COMMUNICATION BARRIERS

- SYMPTOMATOLOGY
- VERBAL EXPRESSION
- REGULATION OF EMOTIONS
- FLAT OR INAPPROPRIATE AFFECT
- SYMBOLIC USE OF LANGUAGE
- DIMINISHED EMPATHY

1. HELP THE CLIENT ORGANIZE HIS THOUGHTS.
2. WHEN THE CLIENT IS TANGENTIAL, HELP HIM RETURN TO THE CENTRAL POINT.
3. PROVIDE SUFFICIENT TIME FOR THE CLIENT TO RESPOND TO QUESTIONS WITHOUT PROLONGING THE SILENCE.

4. ADJUST THE LENGTH OF SESSIONS.
5. REMEMBER THAT CONFUSED VERBALIZATIONS DON'T ALWAYS MEAN THE CLIENT DOESN'T HAVE A MEANINGFUL OPINION.
6. DON'T GET CAUGHT UP IN DEBATING DELUSIONAL MATERIAL.

1. PROVIDE INCREASED STRUCTURE.
2. DON'T HESITATE TO INTERRUPT; DO IT IN A SPIRIT OF INTEREST IN WHAT THE CLIENT IS SAYING.
3. IF NECESSARY, SLOW DOWN YOUR OWN SPEECH.
4. ASK IF THE PERSON WILL SPEAK MORE SLOWLY.

CLARIFICATION AND INFORMAL ASSESSMENT

1. CLARIFYING THE INDIVIDUAL'S CONCERNS AND PERSPECTIVES
2. DETERMINING THE INDIVIDUAL'S EXPECTATIONS OF THE PROCESS
3. UNDERSTANDING THE INDIVIDUAL'S PERCEPTIONS WITH RESPECT TO HIS/HER PREVIOUS EDUCATIONAL AND/OR OCCUPATIONAL EXPERIENCES
4. HELPING THE INDIVIDUAL TO REFORMULATE HIS OR HER CONCERNS

SPECIFIC COGNITIVE RESTRUCTURING TECHNIQUES

1. DIRECT INSTRUCTION ABOUT THE ROLE OF COGNITIONS IN SUBJECTIVE STRESS AND BEHAVIORAL DEFICITS.
2. MONITORING ONE'S PERSONAL THOUGHT PATTERNS
3. MODELING OF A RATIONALISTIC EVALUATION PROCESS AND MODIFICATION OF PERSONAL THOUGHT PATTERNS
4. FEEDBACK ON REPORTED CHANGES IN THINKING PATTERNS AND BEHAVIORS
5. PERFORMANCE ASSIGNMENTS AND REHEARSAL TASKS TO IMPROVE DISCRIMINATION AND EVALUATION OF PERFORMANCE-RELEVANT COGNITIONS.

FORMAL VOCATIONAL ASSESSMENT

- ENABLES BOTH THE PRIMARY CONSUMER AND THE PRACTITIONER TO BETTER UNDERSTAND THE CONSUMER'S INTERESTS, ABILITIES, AND WORK ENVIRONMENT PREFERENCES
- PROVIDES A MORE OBJECTIVE METHOD OF IDENTIFYING STRENGTHS AND DEFICIT AREAS
- INSTRUMENTAL IN THE FORMULATION OF REALISTIC GOALS AND CAN PROVIDE A PROFILE OF CHARACTERISTICS RELEVANT TO CAREER DECISION-MAKING.
- ENABLES A SYSTEMATIC EXPLORATION OF CAREERS THAT MIGHT BE PARTICULARLY ADVANTAGEOUS AND PROVIDES INFORMATION CONCERNING FIELDS TO AVOID AND/OR TYPES OF ACADEMIC REMEDIATION THAT MIGHT BE BENEFICIAL.
- JUDICIOUS TIMING IS NECESSARY IF THE ASSESSMENT IS TO BE BENEFICIAL.

RESULTS OF A FORMAL VOCATIONAL ASSESSMENT MUST TAKE INTO ACCOUNT AN INDIVIDUAL'S SOCIAL SKILL REPERTOIRE, TOLERANCE FOR SPECIFIC STRESSORS, AND CAPACITY TO SUSTAIN GOAL DIRECTED BEHAVIOR.

CAREER EXPLORATION AND SYSTEMATIC DECISION MAKING

IMPLEMENTING THE CAREER PLAN

- IDENTIFYING MANAGEABLE SUBGOALS
- REVIEWING
- SELF-MONITORING

MOTIVATIONAL ISSUES

MOTIVATIONAL ISSUES ARE THE NORM.

MOTIVATION IS A SITUATIONAL PHENOMENON.

UNREALISTIC CAREER GOALS

- SYMPTOM-RELATED
- MODELING
- SUSTAINING FANTASIES
- VALUES AND INFLUENCES

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5

Basic Interviewing Skills

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This chapter focuses on the special dynamics of the interview process and discusses important diagnostic aspects of the interchange between interviewer and interviewee. Special problems encountered in interview situations are discussed along with particular techniques, such as the mental status examination. The emphasis is on using the interview as a specialized diagnostic tool in order to clearly understand each patient for proper diagnosis and treatment planning.

In a certain sense each of us is an experienced interviewer to the extent that we are experienced communicators, since, as Pope (1979) points out, "an interview is a conversational encounter between two individuals [p. 3]." An interview is indeed a communication interchange, primarily (but not exclusively) directional from interviewee to interviewer. Communication is something with which each of us has abundant experience, although some are more facile communicators than others.

Much attention is paid to teaching interviewing skills in mental health training programs because good interviewing is definitely a skill, arguably either inbred or learned, artistic or scientific. As a skill important for a mental health professional, interviewing is taught with emphasis on the listening and understanding aspects of communication. In fact, it is usually the overanxious, inexperienced interviewer who spends a significant portion of the interview speaking rather than listening.

It is clear that the mental health interview is more than simple communication, although the interpersonal skills and experience one accumulates from a natural history of talking with other people will prove invaluable to the perceptive interviewer. The interview is indeed "a special instance of interpersonal relations [Sullivan, 1954, p. ix]." Not every mental health practitioner will be a good interviewer, because just as people bring various experiences; social preferences and interpersonal styles with them to the interview, they have varying potentials for the sensitivity and deductive reasoning skills required of the truly good interviewer.

Matarazzo (1965) points out that interviewing is one of many techniques through which one person exerts influence over another. Historically educators and priests as well as psychotherapists have utilized the techniques of the interview, a term that originally meant "a meeting of persons face to face [Zubin, 1962, p. 403, quoted by Matarazzo]." Too often interviewers pay too much attention to what the patient or client is saying at the expense of noticing how and what they themselves are communicating. Others are preoccupied with their own anxiety about their interview behavior ("What do I say next?") and neglect the patient in the process.

Even though interviewing is essentially the patient talking about himself or herself to the interviewer, the process of communication is dyadic and includes both verbal and nonverbal factors. The influence of communication on relationship and the implications for the initial interview are discussed by Bernstein, Bernstein, and Dana (1974), who state that "each relationship contains the potential for bringing into play the infinite range of emotions – positive, negative, ambivalent [p. 1]." The reciprocal nature of the interpersonal dynamics of the interview situations must be considered by interviewers, who must understand the person being interviewed. Good interviewers respond to both their own and the interviewee's communication with perspective and balance, keeping in mind the importance of understanding how they themselves communicate in the process of trying to understand the patient or client.

We interview in order to understand people and we accomplish this end through the medium of communication, a specialized kind of communication. Particularly in this sense, but also in less formalized arenas of communication, we are aware of many factors that infringe on the process and consequently on the degree to which the purpose of the communication is achieved. Expectations, mood, social attitudes, intelligence – these are only some of the factors that influence interview dynamics. Most often, too, the initial interview is the patient or client's first encounter with a mental health professional; therefore, whatever myths or inaccurate attitudes the patient brings to the interview will be both informative and intrusive. The interviewer must recognize these and tactfully deal with their emergence.

There is essentially no single "correct" way to interview, nor can interviewing easily be taught. Good interviewing requires much practice, careful scrutiny of one's work, and most important, an appreciation of the fact that the interview is a human relationship. There are at least three variables that affect the interviewer-interviewee interaction: (1) content, (2) style of communication, and (3) quality of the interaction.

Content is the actual interview data, the information presented by the client or patient, his or her history, presenting symptoms, and so forth. Much of this information is gained during the interview, although some very useful information can be obtained from reviewing previous medical, school, employment, or psychiatric records, conducting interviews with family members, and having the patient complete a history form or write an autobiography. *Style of communication* refers to the verbal and nonverbal messages given by the patient. An alert, perceptive interviewer will learn as much or more from the way a person communicates as from the content of what is said. *Quality of the interaction* includes patient and interviewer variables — attitudes, expectations, previous experiences, mood, and other factors that directly affect the interpersonal relationship during the interview.

The initial interview is in very many respects like psychotherapy. The characteristics of a therapy interview in which patients speak openly and revealingly about themselves are the same as those that are relevant to a good initial interview. An interviewer or therapist who is intelligent, caring, and perceptive can elicit a successful interview or therapy session. However, while it is desirable for patients to speak freely, it is well to keep in mind that what patients do not say verbally is often revealed in other ways and is vitally important to a clear understanding of them as individuals. Truly successful interviewers and psychotherapists are intelligent people who rely on their life experience, perceptiveness, and general knowledge of theory to understand patients and clients rather than engaging in the academic exercise of fitting the patient or client to a particular theory. Real interviewing, like real psychotherapy, requires commitment and thinking; therefore, it is infinitely more risky than academic exercising, and consequently more effective.

PRELIMINARY CONSIDERATIONS

Purpose of the Interview

Although it is true that there is much similarity between a good interview and a good psychotherapy session, the purpose of the initial interview is not therapeutic *per se*. While a patient may derive cathartic or insightful benefit from the relatively concise investigation of the areas touched on in the interview, the purpose of the interview is primarily information gathering and understanding.

Skillful interviewing allows patients and clients to reveal themselves in the context of a dyadic relationship. In order to foster the patient's self-revelation, the interviewer should refrain from following a structured format. Although haphazard questioning should be avoided, the interview must be loosely enough structured so that the interviewer can pursue avenues of inquiry that present themselves during the course of the interview. As MacKinnon and Michels (1971) point out, "The interview is most effectively organized around the clues provided by the patient and not around the outline for psychiatric examination [p. 28]." Interviewers generally start interviews with the general goal of understanding patients in their individuality, but may also have a more specific goal depending on what they want to know about a particular patient. Immediate and unfolding impressions of the patient, as well as topics introduced by the patient, guide the skillful interviewer. The process of a good interview can best be described as hypothesis formation and hypothesis testing. Impressions of the patient are formed and investigated and the interview is not completed until the interviewer understands the patient.

Keeping in mind that understanding the patient is the overriding purpose of the interview, our understanding is often guided toward a specific end, depending on circumstances. The setting in which the patient or client is seen often generates certain guidelines, as will be seen in the following list of specific interview purposes.

Diagnosis. Hospitals, mental health clinics, social agencies, and veterans hospitals all have requirements for diagnostic classification that must be met. Third-party payers such as insurance companies and welfare agencies have diagnostic requirements with which one should also be familiar. In most cases a DSM-III (APA, 1980) diagnosis is sufficient, although some companies will require elaboration of the diagnosis. A conceptual diagnosis reflecting the psychological processes underlying the patient's problems and incorporating both etiology and prognosis is often useful. Of concern also is the question of whether or not the patient actually has any psychiatric problems at all that merit a diagnosis. The fact that a patient is in a psychiatric setting and is being interviewed does not mean that he or she has a psychiatric condition or actually fits a diagnostic category. Too many interviewers feel compelled, as if by the thrill of the hunt, to find the elusive diagnosis in every patient.

An invaluable and yet often traumatic experience for the mental health professional is the brief hospital consult. In this situation the professional is often asked to interview a patient for twenty to thirty minutes and arrive at a diagnosis. Here the interviewer must pay special attention to verbal and nonverbal clues, efficiently make and check hypotheses, and arrive at an accurate diagnostic impression. Under such circumstances, most psychologists want to administer a battery of tests, social workers want to take a thorough history, and psychiatrists want to conduct a series of in-depth interviews. Relatively few professionals feel comfortable making judgments about psychopathology on the basis of one brief interview.

yet in the practical working world such practice is often a necessity. There are times when important decisions must be made as expeditiously as possible.

Patient management. Whether in an inpatient or outpatient setting, decisions must be made regarding treatment planning. Initial interviews must help the interviewer decide on diagnosis and plan an appropriate treatment strategy. If psychotherapy is selected, the interviewer must decide among individual, group, or family therapy, or a combination; who the therapist is to be; how often therapy sessions should be scheduled; and so on. A good intake interview includes an understanding and explanation of the patient's presenting complaints, conceptualization of the psychopathology, diagnosis, treatment recommendations, and prognosis. The interviewer must ensure that the interview is sufficient to provide this information.

Outpatient treatment versus hospitalization. This purpose is significant enough to be considered singly, although it is essentially subsumed under patient management. Relevant questions for the interviewer to keep in mind are: Can the patient manage the daily affairs of living on his or her own? How much support is there in the patient's environment? What other alternatives are available? What are the patient's financial resources? How willing is the patient to be hospitalized? Is the patient capable of determining a rational course of action and judging what is in his or her own best interest?

Deciding on a test battery. When interviewing a patient with whom a psychological evaluation is scheduled, the psychologist will want enough information to enable selection of an appropriate test battery. Intellectual and achievement tests may be selected on the basis of an assessment of the patient's intellectual status. If the clinician thinks the patient manifests organic symptomatology during the interview, a neuropsychological battery might be called for. Particular personality and projective techniques should be selected based on the cooperation of the patient, his or her intellectual and motivational level, and the particular questions to be answered. The interviewer should always find out what questions the referring person wants answered. What is the patient's perception of the purpose of testing? Is the patient cooperative, manipulative, honest, hostile, withdrawn? Impressions formed during the initial interview will help with both test selection and management of the testing situation. For example, does the patient have questions regarding confidentiality? If so, the examiner would be well-advised to clear these up before they interfere with the patient's level of cooperation during the testing session. Who will give the patient feedback regarding the test results? Does the patient expect the examiner or the referring person to talk with him or her afterwards? Clearing up questions such as these prior to testing can eliminate problems with cooperation and motivation that otherwise might cloud the test results.

Disposition. Particularly in an inpatient setting, an interview is often conducted with patients prior to discharge in order to assess their current functioning and assist them in making plans for readjustment to living outside the hospital and for follow-up outpatient visits. An important related question concerns the family's perception of the patient's status and their willingness to readmit him or her into the family structure.

Test feedback. When conducting an interview for the purpose of giving test feedback to a patient or client, the psychologist is normally doing most of the talking, which makes this situation different in this respect from the other interview situations we have discussed. There are several principles the interviewer must keep in mind: (1) Give information to patients commensurate with their capacity to understand and utilize the information. The most eloquently worded explanation will be useless if it is not phrased in such a way that the patient can understand and use it. (2) Give the patient the essential information without elaborate or unnecessary details. A concise message containing the important elements will be easily understood and appreciated by most patients. (3) Take plenty of time so that the patient can ask clarifying questions. (4) Particularly if the patient is a minor, consider carefully what information regarding the test results he or she can accept and utilize. There is no point, out of the context of psychotherapy, in confronting patients with troubling information except as it encourages them to enter treatment. (5) Again, if the patient is a minor, arrange to give feedback to his or her family. In the case of an adult, feedback may be given to family members as long as it is in the best interest of the patient, and in most instances should be done only with the patient's (or his or her legal representative's) written permission. It is particularly important to involve family members in a feedback interview when patients are incapable of making good decisions for themselves and the family will be called upon to decide upon treatment in the patient's behalf. (6) The referring person is entitled to some form of test feedback. Those involved in primary care of the patient should be given as detailed a report as is possible.

History taking. The interview designed to elicit historical information alone is a specialized technique usually performed by social workers. However, other mental health professionals often wish to obtain a history as part of their initial interview. These interviews normally involve a more structured format than the diagnostic interview, although a good interviewer can take a history while seemingly engaging in pleasant conversation with the patient. Certain areas of prime interest will be investigated in more detail, depending on the purpose for obtaining the information.

A thorough history should include the following categories of information as

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obtained from the patient.* The interviewer should make a special effort to note the patient's own words, as this method often reveals salient information about the patient's thoughts, attitudes, and emotionality.

1. *General information:* demographic data (name, age, sex, occupation, marital status, address, telephone numbers, religious preference), a list of close relatives, and the name of the referral source.
2. *Patient's narrative:* chief complaints, the patient's description of problem history, duration and severity, previous therapy, the kind of assistance presently sought, the patient's evaluation of present general health, and the interviewer's impression of the patient's reliability as an informant.
3. *Personal information:* height, weight, interests, hobbies, and friends.
4. *Medical history:* data from birth to the present: list all illnesses, surgeries, and medications.
5. *Occupational data:* current and previous employment.
6. *Sex information:* past and current sexual interests and behaviors.
7. *Menstrual history (females only):* age at menarche and current description of menstrual periods.
8. *Marital history:* data relevant to present and previous marriages and children.
9. *Family data:* information about natural parents, stepparents, and siblings.
10. *Alcohol and other toxins:* information about alcohol and drug use, poisons ingested, nicotine, glue, and paint.
11. *Family mental history:* information about psychiatric treatment for any family members.

Interview Data

MacKinnon and Michels (1971) identify several factors which constitute the data of an interview, which all interviewers should keep in mind.

Content and process. *Content* is the verbal and nonverbal substance of an interview, including both the information provided by the patient and the interviewer's interventions. It includes what patients and clients say as well as the nonverbal messages they give. A patient might tap his or her fingers rapidly on the arm of a chair, for example, while talking about looking for a new job. *Process* refers to the implicit meaning of content in the context of the interviewer-interviewee relationship. Content is what happens and process is what it means. Process is not inferred at the conclusion of the interview. It is ongoing, and develops with the interview as a continuous and integrated whole. Communication in an interview is a two-way process; the interviewer's reactions to the patient are part of the content, whose meaning gives important process information.

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*Another outline for the psychiatric history is given in Menninger, K. A. *A manual for psychiatric case study*. 2nd Ed. New York: Grune & Stratton, 1962.

Introspective and inspective data. *Introspective* information is that provided directly (usually verbally) by patients, their accounts of their own feelings and experiences. *Inspective* data, on the other hand, is the information contained in the nonverbal behavior of the patient and the interviewer.

Affect and thought. It is important to distinguish between emotional reactions *(affect)* and intellectual productions *(thought)*. Many patients, when asked how they feel about some aspect of content, will state their thoughts — intellectualized responses devoid of any personal revelations of feeling. While the interviewer notes the patient's verbal description of feeling, he or she also takes into account paralinguistic and nonverbal information. In examining a patient's thinking process it is important to look at content, rate of production, and organization.

The Interviewer

It is vital that clinicians as interviewers be aware of the way they present themselves to patients so that they can understand the patient's behavior in the correct context. Interviewer directiveness has been shown to reduce patient self-exploratory statements (Bergman, 1950), to increase defensiveness in patients who were more defensive or more aggressive before treatment, but to decrease defensiveness in those who had felt a greater need for autonomy (Ashby, Ford, Guerney, and Guerney, 1957), and to improve outcome for patients exhibiting external locus of control (Abramowitz, Abramowitz, Roback, & Jackson, 1974). Pope (1979), in his review of the literature in this area, suggests that interviewer directiveness is a reflection of the type of patient being interviewed, with more dependent patients evoking more directiveness on the part of the interviewer.

Interpretations on the part of the interviewer have been shown to meet with various interviewee responses. Pope's (1979) review of these studies suggests that interpretations can decrease patient verbal productivity (Kanfer, Phillips, Matarazzo, & Saslow, 1960) unless used as verbal conditioning reinforcers, in which case they increase productivity of preselected words (Adams, Butler, & Noblin, 1962; Adams, Noblin, Butler, & Timmons, 1962; Noblin, Timmons, and Reynard, 1966). Other research has demonstrated that interpretations of moderate depth are more productive than either shallow or deep interpretations (Shaffer & Shoben, 1967; Speisman, 1959), and some authors (Bernstein, 1965; Fisher, 1956) advise against deep interpretations in the interview.

Several studies indicate that high levels of interviewer activity enhance positive therapeutic outcome (Rice, 1965) and facilitate patient perception of empathy and warmth in the interviewer (Lennard & Bernstein, 1960; Truax, 1970; Pope, Nudler, VonKorff, & McGee, 1974). Other factors such as ambiguity of interviewer statements (Pope & Siegman, 1965; Pope & Siegman, 1968; Siegman & Pope, 1965), interviewer affect statements (Isaacs & Haggard, 1966), and interviewer expressiveness (Wexler & Butler, 1976) have been shown to increase patient activity and expressiveness in an interview.

The point of this research evidence for clinical practice is that it suggests how interviewers can affect interviewee variables to enhance a productive interchange by manipulating their own behavior during the interview. As mental health professionals, we must be aware that we have a tremendous effect on patients and clients: we must be aware of that effect so that we can properly interpret a patient or client's behavior.

The interviewer's appearance and manner are the most readily influential characteristics. An interviewer whose physical presentation elicits confidence from the client or patient will have a more successful interview than one whose appearance leaves his or her professional status in doubt. The interviewer's dress and grooming should exemplify self-respect and competence. Many patients will feel that interviewers cannot respect them and take them seriously unless they manifest these attitudes toward themselves. The interviewer's posture, handshake, and overall bearing will affect the patient either favorably or unfavorably.

Pope and Siegman (1972) found that interviewers who were perceived as experienced elicited more productive (verbose) responses in shorter response times than did inexperienced interviewers, but that these responses might involve little self-disclosure. Pope, Nudler, Norden, and McGee (1976) and Pope, Nudler, VonKorff, and McGee (1974) compared interviewer experience levels and found a mixture of facilitating and inhibitory effects due to status (experience). It was clear in these investigations that a factor such as social compatibility influenced the interview interaction in such a way that the novice interviewers engaged in a less formal, more conversational dialogue with patients than the experienced interviewers. Pope (1979) concluded that "the social proximity between interviewer and interviewee may be more salient in some situations than the expertise and experience of the interviewer [p. 265]."

In this writer's experience, it takes skill to make a conversational interview — one that the patient is likely to report in pleasant terms — a productive interview as well. Interviewers should be mindful of the fact that disturbing material sometimes must be discussed, albeit in a nonthreatening manner, in order for an interview to reveal pertinent information about the patient. Accurate understanding is a more important goal than pleasant conversation, even if the interviewer is personally anxious to keep unpleasant topics from being discussed. It is evident that whatever other factors are operative, the interview is basically a special case of an interpersonal communicative relationship betwen two people. As interviewers we will do well to be mindful of the fact that we are personally part of that communicational dyad, that we are what Sullivan (1954) calls "participant observers [p.19]." This means that the communication is two-way during an interview. Sullivan observes that "to the extent that he [the interviewer] is unconscious or unwitting of his participation in the interview, to that extent he does not know what is happening [p.19]."

The Interviewee

There are several often-overlooked factors that the interviewer should consider in evaluating and understanding an interview with a patient or client, for these factors can have a significant effect on the content and process of an interview. It has long been clear that the expectations patients bring with them to the interview greatly influence the behavior they exhibit while talking with the interviewer. There is evidence that patients' expectations of a therapy encounter depend on the psychotherapeutic approach they anticipate will be used (Lennard & Bernstein, 1960) and on the professional status of their therapist-interviewer (Chance, 1959; DeHaan, 1962). Male and female patients might expect interviewers to behave in different ways (Apfelbaum, 1958), and a patient's socioeconomic status is often an important determiner of expectations (Heitler, 1973; Strupp & Bloxom, 1971). Overall and Aaronson (1963) suggested that middle-class patients expect the therapist to assume less direction, authority, and responsibility than did lower-class patients. Jacobs, Muller, Anderson, and Skinner (1972) found a significant tendency for patients who had improved after psychotherapeutic treatment to have had more positive self-reported pretherapy expectations of the psychotherapy encounter than had unimproved patients.

Evidence has indicated that patients' role expectations influence their behavior during therapy (Jacobs, Muller, Anderson, & Skinner, 1972; Kelley, 1955). Several efforts to utilize role induction procedures in order to align patients' expectancies with the realities of therapeutic interactions have met with success (Heitler, 1973; Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Marlatt, Jacobson, Johnson, & Morrice, 1970; Sloane, Cristol, Pepernik, & Staples, 1970; Spiritas & Holmes, 1971; Strupp & Bloxom, 1971; Yalom, Houts, Newell, & Rand, 1967). This writer (Johnson, 1975) demonstrated that patients' expectancies of active or passive participation could be altered in a positive direction, but that altered expectancies are not quickly translated into behavior in one interview. Thus even though patients' expectancies are directly changeable in an ongoing therapy situation, patients probably behave within one interview in accordance with their preconceived expectations. For this reason, the interviewer does well to pay attention to clues to such expectations and to evaluate to what extent they influence the patient's observable behavior.

Also, patients and clients respond to their perception of the interviewer and the interview situation itself. The interviewer must be aware of these factors in order to assess their possible influence. For example, on one occasion the present writer, then a student interviewer working in a hospital, was obliged to conduct an interview of a neurotic adolescent and her parents in an undesirable location, due to a shortage of office space during a period when offices were being moved.

Growing concern was evident on the parents' faces as we left the reception area, took the elevator to another floor, and walked through several corridors to a distant part of the hospital in order to find a private interview room. An explanation of the situation comforted the parents and the interview progressed smoothly, but the outcome would undoubtedly have been quite different if the interviewer had not been perceptive of the patients' reactions to a change in setting that contradicted their expectations.

Equally important is the presence of anxiety that normally is evident in most people in a new situation. Anxiety is often heightened in the psychiatric interview situation, particularly if patients are aware that diagnostic and treatment decisions will be made based on their "performance" during the interview. Many patients draw the analogy of a job interview or a consultation with a medical doctor.

Some patients evidence better relationship skills than others (Isaacs & Haggard, 1966), while some are simply more likable than others and tend to produce desirable interview behavior and to be disclosing and verbally fluent during the interview (Pope & Nudler, 1973). All of these factors should be considered by the interviewer as potential influencing factors on patient behavior and its interpretation during an interview.

Finally, the interviewer should be aware that any psychopathology that is manifest in the patient's behavior will itself affect the course of the interview. Pope (1979) illustrates this process with several examples. The schizophrenic, he notes, will often relate to the interviewer's questions in an autistic or irrational manner and, if stressed, can "retire behind an impermeable wall of speech that is not readily understandable [p. 431]." The obsessive patient, on the other hand, will appear to be the most rational and articulate of patients until the interviewer realizes that he or she has been seduced into an intellectual contest and has become "an accomplice of the interviewee in banning any expression of personal feelings [p. 432]."

THE SETTING

The importance of a patient's expectations as they relate to the interview process was discussed earlier. One thing that patients and clients universally expect, and rightfully so, is to receive professional care from a person who takes his or her job seriously. Patients and clients hold this expectation because they want to be taken seriously, and regardless of how it sounds to anyone else, their problems are serious business to them. Indeed, many patients begin the interview by implicitly asking to be taken seriously — "I hope you won't think I am crazy."

Many patients have little if any experience with mental health professionals. They do, however, usually have some experience with physicians. One influence of this prior experience is normally that the patient expects all health professionals to be just that — professional. It is the clinician's responsibility to provide the patient with a comfortable, pleasant atmosphere in which to talk about his or her problems, concerns, and aspirations. This task is made difficult by the very atmosphere of certain settings in which interviews must be conducted. Hospitals, prisons, rehabilitation centers, and the like do not engender feelings of privacy and confidentiality in patients. Therefore special measures must be taken in order to generate an atmosphere conducive to an open, self-disclosing interview. A private room, preferably not a corner in a large conference or recreation room, where one can arrange to be undisturbed by patients, staff, and visitors, is highly desirable.

The aesthetics of the interviewing room should convey a professional atmosphere of comfort and security. The setting in which one works might impose certain limitations on furnishings for the office: nonetheless, in most situations the furniture available can be placed in a comfortable, conversational arrangement, and paintings and other accent pieces can be selected to convey the appropriate mood.

The purpose of the interview is to help clients and patients reveal themselves so that the interviewer can understand them. Interviewing the patient while sitting behind a desk not only destroys the conversational mood, but also inhibits a full view of the patient. Generally the best arrangement is to sit facing the patient with both participants in chairs that are approximately the same height. Sitting the patient significantly lower or higher than the interviewer unnecessarily imposes an additional variable on the interview process.

Attention should also be paid to other aspects of the environment, such as temperature, ventilation, and lighting. In addition, the room should be relatively quiet and the clinician should arrange to be undisturbed during the interview. It is difficult to convey a feeling of confidentiality if other people are coming in and out during the interview, or if telephone calls constantly interrupt.

It is a good idea not to sit between the patient and the door. Sooner or later the interviewer will interview a psychotic patient who impulsively decides to leave the room by storm or whose "voices" are so frightening that he or she flees in panic, oblivious to the unsuspecting interviewer sitting directly in the way.

Equally as important as the appearance of the interviewing room is the clinician's personal appearance. The patient's confidence in the professional will directly influence the degree to which he or she speaks freely and openly during the interview. The interviewer should not only be well-groomed, but should also dress appropriately for the setting in which he or she works. Although everyone has the right to personal standards, it is well to remember that the professional engages in a special relationship with another person and therefore has a special responsibility. The clinician demonstrates respect for himself or herself and for the patient by dressing in a professional manner, and by doing so fosters the cooperation of the patient. It is inaccurate to interpret as pathological a patient's negative reaction or reticence to talk if it is a justifiable response to the interviewer's inappropriate appearance or behavior.

Psychologists' professional organizations encourage the provision of an appropriate setting for the conduct of work with patients and clients as a professional responsibility. The American Psychological Association, for example, states in the *Standards for Providers of Psychological Services* (January 1977 revision):

> Physical arrangements and organizational policies and procedures should be conducive to the human dignity, self-respect, and optimal functioning of users [patients], and to the effective delivery of service. The atmosphere in which psychological services are rendered should be appropriate to the service and to the users, whether in office, clinic, school, or industrial organization (p. 111).

Special mention should be made of the interview conducted in a hospital setting. Whether patients are hospitalized on a medical or a psychiatric ward, they are usually in a state of mind characterized by feelings of helplessness and dependence. Patients react to these feelings in various ways, depending on their personality and any psychiatric conditions they may be experiencing. Typically patients have not requested the consultation, and often interpret any psychiatric intervention, even a simple interview, to mean that their physician or family considers them to be "crazy." Thus the interviewer often encounters a defensive or hostile patient. In this regard, much depends on what patients were told about their hospitalization and how they were prepared for the interview. The interviewer is well advised to investigate these factors before seeing the patient. If the patient has not been informed about the interview or has been inaccurately informed, this must be cleared up with the patient at the start of the interview.

It is also a good idea to review the patient's hospital chart and to talk with nursing personnel and others who have had frequent contact with the patient prior to actually conducting the interview. Much can be learned through these procedures that will prove invaluable during the conduct of the interview. It is both courteous and desirable to talk also with the referring person prior to seeing the patient.

A significant problem in hospital interviews is the patients' reluctance to talk openly about themselves because of the lack of privacy engendered by the hospital setting. Patients are constantly observed and their behaviors noted while they are hospitalized, and they understandably react. The perceptive interviewer will note this reaction in the patient, empathically acknowledge it, and endeavor to keep the interview as private as possible. It is often advisable with particularly wary patients to discuss with them the nature of confidentiality in the hospital, telling them who has access to information about them and what use may be made of it. In conducting the interview, use of a private interview room is desirable. If the patient must remain in bed, draw the curtains and speak in a relatively soft voice. Ask other patients and visitors to leave the room so that you can converse privately with the patient.

At the conclusion of the interview, a note must be put in the patient's chart.

either in the Progress Notes or on a special consultation sheet used by many hospitals. The interviewer should be thoroughly familiar with hospital policies and procedures before interviewing the patient. The chart note should be concise and well organized. If the hospital uses a system such as the Problem-Oriented Medical Record (POMR), the note must be in that format. The note should include significant interview data, assessment, diagnosis, prognosis, and treatment recommendations. A personal communication by telephone and/or letter with the referring person is also highly advisable.

A further word is in order regarding the POMR system, since it is enjoying increasing acceptance in mental health settings. The POMR is a record-keeping system that emphasizes the route from problem identification to problem solution. There are essentially five phases to the system:

1. *Initial evaluation*. A good initial evaluation provides for goal-setting for the patient, family and staff, diagnosis, treatment plan, and anticipated length of treatment.
2. *Data base*. The data base includes history and results of present medical and psychiatric examinations.
3. *Problem list*. A problem is defined as anything important enough (to the patient, family, or staff) to do something about. The POMR system requires that all problems be numbered and listed so that treatment plans can be clearly formulated and progress noted.
4. *Treatment plans*. Treatment goals and the methods used to attain the goals are listed separately for each problem.
5. *Progress notes*. Daily progress notes are written for each problem listed on the problem list. The S-O-A-P format is used as follows:
   a. *Subjective:* what the patient, family or staff say about the problem.
   b. *Objective:* results of studies or direct observations regarding the problem.
   c. *Assessment:* current formulation of the problem and evaluation of treatment effectiveness.
   d. *Plans:* what is to be done to solve the problem.*

In the next section of this chapter we shall examine the phases of the interview and discuss ways to handle each phase in a skillful manner.

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*Two excellent references for the POMR are: Meldman, M. J. *The problem-oriented psychiatric index and treatment plans*. St. Louis: C. V. Mosby, 1976; and Ryback, R. S. *The problem-oriented record in psychiatry and mental health care*. New York: Grune & Stratton, 1974.

PHASES OF THE INTERVIEW

The Beginning

The appointment and the waiting room. The experienced interviewer realizes that the interview begins at the time the appointment is made. Much can be learned about patients from a receptionist's description of their behavior on the telephone. For example, this writer recently saw a twenty-year-old man with the presenting complaint of anger over a smothering family and the desire for independence. His mother had called to make his appointment, at his request.

A well-coached receptionist can also provide an interviewer with an accurate account of the patient's behavior in the waiting room. How patients describe the purpose of the interview, how they relate to the receptionist, other people in the waiting room, and any family members accompanying them, and how they respond to a request to supply the receptionist with the usual name, address, and telephone information all provide the interviewer with valuable insights.

The referral. Discussion with the referring person prior to interviewing the patient is not only good etiquette, but also offers the interviewer an opportunity to learn something of the background of the patient, why he or she was referred, and what his or her preconceptions and attitudes toward the interview are likely to be. Experienced interviewers prefer to have every scrap of available information about the patient at their disposal, both for hypothesis formation and for validation of hypotheses.

Initial observations. The good interviewer begins observing as soon as he or she lays eyes on the patient. Notice how patients sit and how they respond to your initial greeting. When you call the patient's name and introduce yourself, notice his or her handshake, eye contact, and any comments he or she makes. Notice posture, facial expression, voice quality, grooming, and gait as you greet patients and escort them to your office.

If the patient is a child or adolescent accompanied by parents, or an adult accompanied by spouse or family, greet the patient first, even if you have spoken with another family member on the telephone to arrange the appointment for the patient. Ask the patient to introduce the other family members to you, noticing speech patterns, nonverbal behavior, and the order of introductions. Remember that the welfare of the patient is your first concern — greeting patients first gives them that message. Do not run the risk, especially with an uncooperative patient who is being interviewed involuntarily, of further alienating the patient by giving the impression of being in alliance with the patient's family.

Be sure to start the interview on time. If you begin the appointment early, some patients will interpret this as overeagerness on your part and will question your motives. If you start quite late, some patients will feel you are uninterested in them. It is advisable to avoid having to deal with these unnecessary complications. If you are going to be late starting the interview, ask the receptionist to inform the patient.

In the interviewing room. It is normally a good idea to show the patient into the interviewing room and invite him or her to be seated. Some interviewers like to provide several possible seating arrangements and watch patients make their choice. What can be learned in this situation is how readily patients make a decision and whether or not they need to ask the interviewer for guidance. Some degree of awkwardness upon entering a new room is perfectly normal; therefore, interpretations of the patient's behavior in this situation must be made carefully.

When patients are accompanied by family or friends, it is usually a good idea to offer to see them alone before talking with their family. In the case of a particularly uncommunicative patient, this interview might be brief. Seeing the patient first is respectful and reassures him or her that the interviewer has the patient's best interest at heart. It is not a good idea to ask a patient's permission to talk with their families (they might refuse), but it is advisable to inform them of your intention to talk with their family and ask them how they feel about your doing so.

It is often a good practice to offer to bring in the family at the conclusion of the interview with the patient, thereby seeing the whole family together after having established a relationship with the patient. Comparison of the patient's behavior while talking alone with the interviewer and his or her behavior while the family is present is usually very enlightening for the interviewer. Some families ask to talk with the interviewer privately, which is usually permissible and most often means that they have particular questions, concerns, or information that they do not wish the patient to hear.

If the patient's family is with him or her, it is advisable to talk with them one way or another. Their presence indicates that they are concerned and that they have something to say. Additionally, they can provide clarifying information and correct any false impressions that the patient may have given the interviewer. For example, occasionally patients will try to "con" the interviewer into believing that they have problems (or that they have none). Information from the patient's family can help validate or invalidate the patient's perceptions and statements.

The Middle

The presenting complaint. Most patients expect some direction from the interviewer at the beginning of the appointment. Many patients feel so overwhelmed by their problems that they seem not to know where to begin, and some will verbalize these feelings. Most often, though, the interviewer becomes aware of this feeling in the patient's tone of voice, facial expression, gestures, and other nonverbal behaviors.

A good starting point is to briefly let the patient know what information you have received from the referring person — for example, "Dr. Smith told me that you have felt low in energy lately." This kind of statement informs patients that you already know something about their problems and that you are interested enough to have spoken with the referring person. Patients then have a starting point from which to elaborate on their problems. Some interviewers prefer to start by telling the patient to "begin wherever you want to," to "tell me what concerns brought you here today"; others simply sit in silence and let the patient take the initiative.

All patients want to "tell their story" in their own way, and it is important that the interviewer let them do just that. The sequence in which patients tell their story, the problem areas they emphasize, the words they choose, the affect they display, the way they explain their understanding of their problems — all these aspects of patients' stories give the interviewer valuable information.

The best rule is to start with general questions and see how effectively patients can structure their responses. Often psychotic patients will tell an incoherent, illogical story, depressed patients a short story — the way patients present themselves tells the interviewer a lot about them. General questions such as "Tell me about yourself," "Describe your family life," "What problems brought you here?" give patients the opportunity to structure the answer in their own (revealing) way. More specific questions can be asked as needed. As Pope (1979) points out, "Self-disclosing and expressive communication is fostered by interview conditions of sufficient ambiguity to permit a communicational interaction to develop. Whatever the orientation of the interviewer, he must find a balance between enough ambiguity to permit the interviewee to speak freely and expressively and enough structure to conduct the communication into channels that are considered important by the interviewer [p. 98]."

The basic principle with which you should conduct every interview is to let the interaction flow naturally. Do not structure the interview with an outline or a predetermined format. Talk about the areas needed in order to understand each particular patient.

The most common mistakes. Inexperienced interviewers share one attribute — they tend to make the same mistakes.

1. Talking too much. Many interviewers who are anxious (often more so than the patient) exhibit their anxiety by talking incessantly. Often they feel that they must ask *all* the right questions, which usually comes out as asking too many questions. The good interviewer says very little and lets the patient do the talking. If you begin to feel anxious while conducting an interview, that is the time to be quiet.

2. *Trying to help.* Good samaritans have no business conducting initial interviews. The initial interview is not psychotherapy; it is for the purpose of understanding the patient, not helping *per se*. The interviewer must pay attention to listening and looking and leave the helping until later. The first interview is the

worst time to give advice, however much you are impressed with your insights into the patient's problems. Too much too soon is deadly and absolutely *not* helpful to patients, even though you err with the most altruistic of intentions.

3. *"Tell me a little about . . ."* Every student this writer has observed has asked patients to say "a little" about something or the other, and then has expressed surprise when the patient did not say very much. Listen to what you ask patients before you render a diagnosis based on their responses. An appropriate answer to the question "Can you tell me something about your childhood?" is "Yes, I can."

4. *Rephrasing questions*. How many times have patients heard, "Tell me about your marriage, how do you feel about it? Do you and your wife argue?" This anxious young interviewer asked three questions in the same breath, and then was uncertain how to interpret the patient's response. Patients who are not confused when they start the interview may well leave very confused if you ask several questions at once. Ask only one question at a time. If the patient requires clarification, then rephrase.

5. *Asking multiple choice questions*. Questions that can be answered with a simple "yes" or "no" do not encourage a patient to elaborate. "Tell me about your wife" is preferable to "Do you love your wife?" By the same token, questions that suggest a choice of answers usually elicit uninformative responses. "Tell me about your job" is preferable to "Do you like your job or not?" and to rapid-fire short questions such as "Where do you work? Do you like it? What do you do there?"

Develop rapport. Rapport between two people exists when they have established a mutual purpose in the context of a comfortable relationship. Regardless of an interviewer's theoretical orientation, the value of interest, empathy and a sincere effort to understand the patient in fostering cooperation in an interviewee is inarguable. Some authors speak of "accurate empathy, nonpossessive warmth, and genuineness" as basic factors that underlie all successful psychotherapy (Truax & Carkhuff, 1967). Since rapport must be developed quickly in the initial interview, it is well for the interviewer to facilitate the same kind of responsive rapport he or she would develop in a psychotherapy situation. Interviewers who naturally exhibit these qualities will easily communicate well with most interviewees and will be better interviewers in the long run than those who learn to "perform" these qualities.

A discussion of confidentiality often hastens the development of rapport, particularly with children and adolescents. Some young people view the interview as proof that they are "in trouble" and assume that whatever they say and do will be reported directly to their parents or to school authorities.

Questioning. Many poor interviewers are unsuccessful simply because they conduct an interrogation rather than an interview. Questioning should be done in a way that makes the patient feel free to open up. Good questions often utilize the patient's own words — for instance, asking a patient to "Tell me more about . . ." a situation he or she has just described, or asking for clarification by simply saying, for example, "You said you disliked your employer. Tell me more about that." This kind of questioning is open-ended so that patients can respond by *structuring their own answers.*

It is very important to clarify terms that the patient introduces. Inexperienced interviewers take it for granted that they know what patients mean when they complain that they are "depressed" or have "bad nerves." In a recent example brought to the attention of this writer, "bad nerves" referred to a delusion that the patient's nervous system was rotting away. Clarification of contradictions should be accomplished in a nonjudgmental way.

Some patients wander from topic to topic, thereby demonstrating a thought process disorder, and should, after a short period of time, be given more structure. Once tangentiality, for example, is demonstrated, no purpose is served by permitting the patient to go farther afield. The patient will feel more comfortable and you will obtain more useful information if you give the patient a reference point, by saying, for example, "Go back to what you said earlier about your son," or "I'm having trouble following you, start again."

Look for changes. As patients tell their story and respond to questions, watch for points of change, conflict, or confusion. Many patients who deny a precipitating event, for example, tell a story in which at the time they became depressed they experienced the death of a loved one or a change of fortune on the job. Inquiry into their experience of these change points in their lives can provide valuable information regarding the etiology of their problems. Also, themes that are repeated by the patient, such as feelings of failure or anxiety in heterosexual relationships, are usually indicative of important material.

Elicit affect. When there are verbal or nonverbal signs of affect, help the patient clarify what he or she feels with statements such as "That must have been pretty sad," or "It sounds like you feel angry about that." The way in which the patient responds to the interviewer's probe will illuminate the patient's degree of insight. On occasion, encouraging a patient to talk further about a subject that you noticed elicited nonverbal expression of affect will illuminate important feelings.

If a patient exhibits a depressed mood and you have reason to suspect suicidal thinking, be sure to talk with the patient about suicide, possibly by asking, "Have you ever thought of hurting yourself?" For a more thorough discussion of suicide, see Chapter 8 of this volume.

Delusions and hallucinations. Delusional patients may talk about their delusions, in which case it is important that the interviewer encourage the patient to talk about them without agreeing with or validating the delusions, either explicitly or implicitly. It is advisable to ask for more information by asking the patient to explain the delusion, such as "Why is the FBI looking for you as oppposed to someone else?" A good check for reality testing is to ask the patient why the anxiety, marital conflict, or whatever is happening to him or her. It is permissible to respond to patients' queries as to whether you see or hear their hallucination by saying that you do not see or hear it but asking the patient to describe it to you in detail.

Empathy. Empathy implies understanding, not necessarily agreement. The interviewer can identify a patient's affect without openly evaluating it. Many patients look for validation of unjustified feelings and attitudes and can easily entrap an unsuspecting interviewer who intends to empathize. For example, one patient complained bitterly that his parents had verbally and physically abused him as a child and talked of how angry he felt about the mistreatment. The student interviewer took the patient at his word and "empathically" responded, "Your parents certainly sound terrible. I can see why you are so angry." The student later discovered that the patient exaggerated the abuse in order to justify his drug abuse and disregard for his family. An empathic statement would have been "You seem to feel angry because you believe you were abused." Empathy reflects accurate perception of patients' feelings, but it should not imply concurrence with their reasoning.

Taking notes. Some interviewers feel apologetic about taking notes during an interview, believing that their full attention should be directed toward the patient. At the other extreme, overanxious interviewers write down practically everything a patient says, fearing that otherwise they will miss a vital piece of information. A middle course is preferable. Many patients reveal too many details for an interviewer to recall accurately. Sketchy notes taken during an interview can be filled in afterwards to ensure that important topics, dates, and names are correctly remembered. In addition, most patients perceive note taking as a sign that the interviewer is interested in them and takes seriously what they are saying.

Silence. Ideally the patient is more anxious during a period of silence than the interviewer, and consequently will break it by resuming the conversation. All too often, however, interviewers interpret a patient's silence as an indication that they should ask another question. If this happens, the interviewer is likely to miss important information about the patient out of concern that a proper interview be conducted. Most beginning interviewers (and some not-so-beginning ones) conduct terrible interviews because they are too concerned with their own "performance" and their demonstration of either exquisite skill or (they fear) exquisite stupidity. When this happens the interviewer is too self-absorbed to concentrate on understanding the patient.

If the patient is silent because he or she is obviously wrestling with a problem, it would be a mistake for the interviewer to break the silence by asking another question. Instead the interviewer should wait for the patient to resume talking. If the patient appears to be withdrawing into an uncommunicative fantasy, or obviously intends to remain silent, the interviewer should respond with something such as "You fell silent after you said [the patient's last comment]," or "Are you uncomfortable because something is difficult to discuss?" If possible, help patients identify the feelings they are experiencing, thereby reassuring them that you want to discuss even difficult feelings with them. At times psychotic or depressed patients will become silent and will speak no further. On these occasions the interviewer should discontinue the interview and resume at a later time.

Restless patients. Occasionally an overly anxious or manipulative patient will want to get a drink of water or go to the rest room in the middle of the interview. Usually telling the patient that you are almost finished and asking him or her to postpone the trip to the water fountain or to the rest room until the end of the interview will be acceptable. Patients on certain medications experience dryness of the mouth to the point that they have difficulty talking without frequent use of a glass of water. Giving these patients water facilitates the interview process.

Some patients may pace the room restlessly. There is no point in insisting that they sit calmly; they would if they could. In most instances these patients will talk nonstop while they move around the room, and the interview data is readily available.

Under no circumstances should an interviewer attempt to physically prevent a patient from leaving the room. If structuring of the situation and a calm, reassuring voice do not settle the patient down, chances are that physical efforts will result in injury, most likely to the interviewer.

Verbal behavior. *How* patients say something is just as important as *what* they say. Pope (1979) refers to Miller's (1973) example of a patient who enthusiastically says, "Oh, isn't that *wonderful!*" and another patient who says the same sentence sarcastically: "Oh, isn't *that* wonderful!" (p. 22). Verbal signals such as tone of voice (Davitz & Davitz, 1959; Pittenger, Hockett, & Daheny, 1960; Pope, Blass, Siegman, & Raher, 1970; Vetter, 1970), rate of speech (Chapple & Arensberg, 1940; Goldman-Eisler, 1952; Saslow & Matarazzo, 1959), and speech disturbances (Mahl, 1961) have been demonstrated to give invaluable information about a patient.

Pope and his colleagues (Pope & Siegman, 1965; Siegman & Pope, 1965, 1966) have demonstrated that interview topics which are anxiety-arousing for patients are disruptive to their speech patterns. Talland and Clark (1954) discovered that the more anxiety aroused by a topic, the more helpful and intimate it was to discuss it in terms of understanding the intimate problems of the patient, even though patients are usually less willing to disclose themselves on high-anxiety topics than low-anxiety ones (Jourard & Lasakow, 1958; Jourard & Friedman, 1970).

Several types of resistiveness have been identified: refusal to talk, superficiality, and use of disqualifying remarks (Watzlawick, Beavin, & Jackson, 1967). Pope and his colleagues (Pope, Blass, Siegman, & Raher, 1970; Pope & Siegman, 1968; Pope, Siegman, & Blass, 1970; Pope, Siegman, Blass, & Cheek, 1972) have investigated the effects of interviewee superficiality and resistiveness, their terms for two primary modes of patient resistance. The effect of such resistance is to inhibit patients' self-disclosure and discussion of psychologically relevant material.

Nonverbal behavior. Elaboration on the message contained in a verbal statement is provided by patients' nonverbal behavior, including their eye contact, (Miller, 1973), physical distance (Sommer, 1974), gestures (Miller, 1973), facial expression (Dittman, 1973; Ekman, 1975; Frijda, 1953, 1958; Thompson & Meltzer, 1964), and body movements (Birdwhistell, 1963). Ekman and Friesen (1974) demonstrated that facial expression is the most salient of all body cues but that it is the easiest to deceptively manipulate. Their evidence suggests that body position, of which people are normally less aware than facial expression, is more honestly expressive of feelings and attitudes. The implication for the interviewer is to observe facial cues and validate them with those from the body. Accumulated research suggests that the voice is most easily made to deceive, then the face, and lastly the hands, feet, and body. Verbal and facial messages may be contradicted by those emanating from the hands, face, and body (Pope, 1979).

There is no doubt that patients say as much or more nonverbally as they do with the spoken word. The good interviewer not only notices nonverbal behavior, but also, on occasion, may call it to the attention of the patient and tie it to the topic at hand. For example, "I noticed that you began to tap your fingers as you started talking about your father." The reason for mentioning the behavior in this way is to further draw patients out, to clarify feelings, and to understand patients' reactions to their own behavior. A good interviewer can learn much about a patient or client by effectively mirroring some statement or behavior and carefully observing the patient's reaction. The interviewer must remember, however, that some patients are threatened by direct comment on their nonverbal behaviors, often to the point of seriously disrupting the interview. Therefore, this type of confrontation must be utilized with judgment. Overly anxious patients, those who have difficulty disclosing personal information, or those who evidence suspiciousness should not be so confronted in the initial interview.

The End

Terminating an interview is problematic for many interviewers, usually because they are unsure what to tell the patient or how to best answer the client or patient's questions. Many patients anticipate a patient-doctor relationship in line with a medical model, meaning that they expect "answers" to their problems and that the "doctor" will take the lead during the interview (Johnson, 1973). This expectation poses difficulties for the interview process and is often particularly thorny at the termination of an interview. The interviewer must keep in mind that patients rightfully expect him or her to share impressions and recommendations with them. This information must be given to patients in understandable terms and must be explained so that they get the message, without giving the impression that "answers" to their problems are being provided. Time must be allowed for answering whatever questions the client or patient has.

At the conclusion of the interview, the interviewer may summarize the process by identifying the basic points brought out by the patient. The interviewer can then briefly encapsulate the meaning of the patient's communications and provide recommendations. The cardinal rule is to communicate in language the patient can understand, or if the patient is too withdrawn or intellectually incapable, in language his or her family can understand. In the situation in which the patient's family must provide follow-up for him or her on the interviewer's recommendation, the interviewer must be alert to and supportive of their intention to do what is best for the patient. Such families often feel guilty that they are doing something unpleasant to the patient and often hold frightening misconceptions about mental health treatment. It is the responsibility of the interviewer to make recommendations that are realistic for the individual patient and that the interviewer genuinely believes will be helpful. For example, if psychotherapy is recommended, you must suggest therapists whom you believe are competent to help the patient. The interviewer also has a responsibility to make recommendations as indicated for treatment other than psychotherapy — for example, medical evaluation or religious counseling.

Some patients ask for a prognostic statement, such as "Is there any hope?", "Am I crazy?", or "Have you ever treated any cases like mine?" In these situations encouraging reassurance is often helpful, along with a restatement of the necessity for following through on the interviewer's recommendations.

It is important to leave time for patients to ask whatever questions they have. Not only do they appreciate this courtesy, but it also gives the interviewer an opportunity to evaluate the patient's understanding of the recommendations. Interviewers often make the mistake of giving the double message of sitting forward in their chair, indicating eagerness to terminate the interview, while asking if the patient has any questions.

Most patients can be relied on to make their own arrangements for recommended treatment. Occasionally there are patients who do not appear to be capable of making their own arrangements and who have little or no family support. In these cases structured, step-by-step procedures are helpful, for example, the interviewer may make telephone arrangements for appointments while the patient is still there. Recommendations can be written down for a patient, if necessary.

Novice interviewers often assume that the very fact that a patient is being interviewed in a mental health setting implies that he or she must have some psychopathology, if only the interviewer is astute enough to discover it. The interviewer then searches for a diagnosis that somehow fits and almost invariably recommends psychotherapy. While it is true that most people who are seen for an initial interview have some concerns, they might not need psychotherapy or exhibit any true psychopathology. Interviewers should not feel compelled to find emotional disturbances where they do not exist. Some people will come to a counseling office when their real problem is medical, financial, or religious.

SPECIAL PROBLEMS

The Depressed Patient

The most common complaint in any mental health setting is depression. The interviewer must quickly learn that patients mean different things by the word "depressed." It is always advisable to ask patients what they mean by the term. In order to investigate the nature of the patient's feeling of depression, the interviewer should inquire about somatic functions, activity and energy level, and what the patient does for fun. Many depressed patients report that they feel listless, do not sleep well, and do not enjoy anything that they used to enjoy. The interviewer must be careful not to simply take patients at their word when they say they are depressed.

The depressed patient often seems relatively uncommunicative and may manifest such a helpless, dependent attitude that a friend or family member immediately takes charge and offers to talk to the interviewer for the patient. The patient's nonverbal communication of depression may be so obvious that a logical starting point for the interviewer is to comment on the patient's appearance of depression. It is not a good idea to challenge the patient's depression. The interviewer should express interested concern without agreeing or disagreeing with the patient's statements.

One problem that often arises with depressed patients is their hopeless feeling that it is useless to talk about their problems because no one can help them. Conversely, they often are so dependent that they seem to want the interviewer to tell them what to do or to solve their problems for them. An interested, professional manner and supportive encouragement is the best approach.

After patients have talked about their depression sufficiently, it is a good idea to inquire about their premorbid adjustment. Any information obtained about precipitating events is helpful. Suicidal thoughts should be explored if they are present (see Chapter 8).

The Schizophrenic Patient

The schizophrenic often appears flagrantly bizarre, but not always. The alert interviewer can observe subtle signs of borderline psychosis. For example, the schizophrenic usually has difficulty coping with most everyday tasks and rarely finds real pleasure in anything. Schizophrenics typically display minimal affect;

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thus the interviewer must be alert and try to elicit the accompanying thoughts as well as the meaning the affect has for the patient.

The schizophrenic might have trouble describing a chief complaint, and if asked, "What brought you to the hospital?" might answer, "A car." His or her confused thinking demands that the interviewer provide more structure than usual, and agitated schizophrenics or paranoids often need reassurance about the purpose and nature of the interview.

Schizophrenics often talk about bizarre or impossible topics, and usually their train of thought is difficult to follow. Interviewers should not make the mistake of giving such patients the impression that they understand the patient's logic or that they agree with or share the patient's delusions or hallucinations. It is at times reassuring to psychotic patients that the interviewer does not share their distorted view of reality. For example, a patient who loosely associates one thought with another might be told, "I don't understand the connection between your parents' divorce and your changing jobs," or "I lost you when you started talking about changing jobs." Certain patients who appear to be sensitive or paranoid might assume that you understand their illogic, even if they do not. It is usually best not to argue with them, as they can become agitated unnecessarily. Most psychotic patients will offer some explanation of their "logic," or state that they do not understand it either. A few patients will ask if you hear the voices, too. A reasonable approach is to answer that you do not hear the voices but that you are interested in the patient's description of them. Statements by a patient such as "My mind is being controlled from outer space," or "I believe Christ is coming soon; He told me so," can be handled by asking for further explanation. It is often helpful diagnostically to ask patients to explain how it is possible for their mind to be controlled or for Christ to speak directly to them. In all of these situations it is important to understand the patient's train of thought and the meaning to them of what they say.

If, during the interview, the patient becomes silent, call his or her name and try to engage him or her in discussing nonthreatening material. Many schizophrenics withdraw when asked a question about a disturbing subject. Give the patient plenty of time to formulate an answer and remember that even catatonic patients are aware of everything that goes on around them during their period of silence.

The Manipulative Patient

The manipulative patient often catches the unsuspecting interviewer off guard with seductive behavior, angry outbursts, questions about the interviewer, and the like. These situations are best dealt with by maintaining a professional demeanor, reminding the patient of the purpose of the interview, and commenting on the patient's remarks in an appropriate manner. Patients may ask, "Have you ever felt like this?" or "Do you think I'm crazy?" as a way of eliciting reassurance. These questions are best handled by reminding patients that you are interested in understanding their feelings and experience. Nonthreatening interpretations of affect are also appropriate, such as "You seem to feel that you are all alone with this problem."

Many patients want to concentrate on blaming others for their problems and try to induce the interviewer to give them advice that undoubtedly will not work, thus setting the interviewer up for blame. Patients often want the interviewer to agree with them about their perceptions and feelings, and in essence want to feel better without having to make changes in their own lives. The interviewer must be careful not to be seduced into agreeing with or feeling sorry for the patient and thus being manipulated into giving advice or telling the patient simply what he or she wants to hear.

The Seductive Patient

One type of manipulative patient deserves special mention because of the harm that can be done if the situation is not handled well by the interviewer. Some patients are sexually suggestive or seductive, either as a defensive maneuver to avoid dealing with sensitive material or as a manifestation of their characteristic way of dealing with people. In either case the seductiveness must not be encouraged, for to do so would be injurious to the patient. It is never appropriate to take advantage of the person in conflict who comes to you for assistance.

For example, this writer became aware of problems a male student interviewer was having in terminating a counseling relationship with a female patient who had entered therapy because of unsatisfying heterosexual relationships. The problem quickly became evident when the counselor, who had recently been divorced, played a tape of a recent session. The clinking of ice in glasses could be heard, and there were references to cards and letters the patient had sent to the counselor proclaiming that she felt warmly toward him and was distressed that he was completing his training and planning to move out of state. The counselor was to a large extent unaware that his divorce and subsequent loneliness had left him vulnerable to flattery, and that he had so enjoyed this patient's attention that he had actually encouraged her seductive behavior toward him. The patient had brought martinis to the session he had tape-recorded, and instead of discussing her feelings and behavior in a constructive way, he had enjoyed the drinks with her.

As another example, this writer recently saw a hysteric adolescent girl on hospital consult. She was seductively attired in a nightgown and lying on top of her bed. The solution was to politely ask her to put on her robe and come to an office down the hall for the interview, thus creating a less intimate setting.

It is rare that a clinician would decide to confront a patient directly about seductive behavior in an interview situation, since that tactic is more appropriate for the therapy situation. Nonetheless, the interviewer must be alert to his or her own attitudes and emotional reactions and to those of the patient so that an appropriate response can be made. The simplest approach is to keep the interview on a professional level and to avoid appearing overly friendly or encouraging. If the patient's seductiveness is interfering with the progress of the interview, a statement reminding the patient of the purpose of the interview and of your role as the interviewer should suffice. Keep in mind that some naive seductive behavior is pathognomonic of certain patients, for example, hysterics, and would be impossible to eliminate during the course of one interview. Also, such patients can easily become offended if you suggest too strongly that they are behaving seductively. Most behavior of this type can be kept within reasonable limits by a gentle reminder of the purpose of the interview and by not allowing the patient to pursue indefinitely topics that lend themselves to seductive or suggestive behavior. Once the presence of a seductive process has been established, you can steer the interview toward more factual areas for a time and thus defuse the situation.

THE MENTAL STATUS EXAMINATION

The Mental Status Examination used to lie primarily in the province of psychiatry, but it is such a useful tool that practitioners in other mental health disciplines have begun to appreciate and use it. The examination amounts to an organized method of classifying and reporting information received during a diagnostic interview. It is not an outline to be rigidly followed during the interview; such a formalized procedure would defeat the interview's purpose. In practice most information relevant to the Mental Status Examination is produced during the course of any good interview. If certain hypotheses (for example, schizophrenia or organic brain dysfunction) are still unconfirmed toward the end of the interview, selected items from the outline may be asked directly.

Although the Mental Status Examination is useful in all interview situations, it is particularly helpful when one is conducting a brief hospital consult and must arrive at a diagnosis and recommendations. In the hands of a skilled interviewer, the Mental Status Examination assists in a thorough exploration of relevant topics. The Mental Status Examination is best learned after one has some experience and has become comfortable interviewing a variety of patients representing various diagnostic categories.

We shall discuss the categories of the Mental Status Examination* in an order conducive to writing a logically formulated report or chart note. The actual use of the examination should be performed in an order consistent with the progress of any particular interview. The outline which follows has been developed by Dr. John Rush and adapted for inclusion in the present volume by this writer. An out-

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*Another outline for the Mental Status Examination, attributed to F. T. Melges, is quoted in Rosenbaum, C. P., & Beebe, J. E. *Psychiatric treatment: Crisis, clinic, consultation.* New York: McGraw-Hill, 1975. A brief form of the Mental Status Examination is given by Kahn, R. L. et al. Brief objective measures for the determination of mental status in the aged. *American Journal of Psychiatry*, 1960, 77, 326 – 328.

line for recording the results of a Mental Status Examination was developed by the present writer based on the Patient Evaluation Report presented in Meldman, McFarland, and Johnson (1976) and appears as Appendix 5 at the end of this chapter.

I. Appearance and Behavior

This category contains all information pertinent to the patient's conduct and manner of presenting himself or herself during the interview.

1. **General description.** Demographic information, such as name, age, race, sex, marital status, children, and occupation, along with a description of salient physical characteristics (height, weight, posture), grooming, and dress.

2. **Motor behavior.** Gait, hyperactivity, eye contact, peculiar or identifying movements, tics.

3. **Expressive mannerisms.** Verbal or nonverbal expressions that appear to be relatively characteristic of the individual patient (for example, lip-smacking, "you know," gestures).

4. **Attitude of patient.** Data relevant to the patient's attitude toward the interviewer and the interview situation (for example, compliance, defensiveness, cooperativeness, hostility, friendliness, seductiveness).

II. Sensorium

This category contains information relevant to the functioning of the central nervous system. Any questions of organic brain dysfunction due to any cause would be investigated here.

1. **Level of consciousness.** Any impairment in general alertness, responsiveness, or consciousness, whether consistent or fluctuating.

2. **Orientation.** *Time* (month, day, year, approximate time of day), *place* (the name of the place where the patient is), *person* (the patient's name), and *present situation* (the patient's awareness of the fact that he or she is being interviewed). Orientation must not be inferred: it must be tested by direct questioning. The interviewer should not be uncomfortable asking for the patient's full name at the beginning of an interview. Asking time, place, person, and present situation questions requires a tactful approach, but is necessary if organicity is suspected.

3. **Attention and concentration.** Normal attention is usually inferred if the patient can attend to the interviewer's questions and comments and does not evidence easy distractibility. The patient who frequently asks that questions be

repeated does not exhibit normal attention. Concentration is tested with "serial sevens" — the patient is asked to count backwards from 100 by sevens. The procedure should be described as starting with 100, subtracting 7, and subtracting 7 from each consecutive answer. An example — "100, 93, 86" — is advisable.

4. **Memory.** Memory must be tested in three spheres:

a. *Immediate.* Tested by asking the patient to recall news events, visitors, activities, or meals that occurred within the past twenty-four hours. Do not ask anything that you cannot verify as accurate.

b. *Recent.* Tested by asking the patient to recall personal events (verified) or news items that happened within the past two weeks.

c. *Remote.* Tested by asking the patient to recall events that occurred longer than two weeks ago. Examples are significant news events such as the year of President Kennedy's assassination or man's landing on the moon. Most patients will answer by recalling their personal activities at the time they learned of the event.

III. Thought Process

Both production and continuity of thought must be considered in evaluating a patient's thought process. Psychotic patients have difficulty maintaining a logical, coherent, smooth-flowing thought pattern and will seem hard to follow because their train of thought is unclear. Circumstantiality, tangentiality, blocking, and loose associations should be noted in this category. Formal testing of thought process is unnecessary because the patient's speech during the interview will make evident any problems in this area. Schizophrenic patients may demonstrate a thought process disorder by exhibiting tangentiality, for example: a schizophrenic man may be talking about his mother and all of a sudden be giving details about his job. A tangential patient often leaves the interviewer wondering how the patient achieved the topical switch unnoticed.

IV. Thought Content and Intellect

Several areas are included in this category, each of which gives valuable insight into the patient's problem.

1. **Characteristic topics and issues.** What does the patient like to talk about? What topics keep coming up? Note should be made of these areas of interest, conflict, or preoccupation because they give the interviewer clues to what is going on in the patient's mind. This writer recently saw a patient who began an interview by talking about how badly he felt because he drank too much, but during the course of the interview he spent a great deal of time discussing problems with his wife, thus giving an insight into the marital conflict that turned out to be the true source of his drinking problem.

2. **Relationship to reality.** In determining the nature of a patient's psychosis, it is important to assess the degree to which he or she is unaware of reality. Autistic thinking, delusions, and hallucinations should be noted with special reference to their content, the manner in which they are expressed, and the affect demonstrated by the patient.

3. **Concept formation.** The interviewer should note whether or not the patient can easily form generalizations and abstractions. Questions useful for this determination are items in the form of the Similarities subtest of the WAIS and proverb interpretation. Most clinicians interpret bizarre responses as indicative of psychosis, concrete interpretations as suggesting an organic process, and low-level abstractions as revealing intellectual deficiences. Examples are: "An orange and a banana are alike because they both reflect light" (bizarre); "The grass is greener on the other side of the fence because the farmer fertilized and watered it" (concrete); "Liberty and justice both have to do with government" (poor abstraction). Relatively simple abstraction items and familiar proverbs are more useful in the interview situation than obscure, highly intellectual items.

4. **Morbid preoccupations.** Persistent or intense reference to death, suicide, destruction, gruesome descriptions, dead or decaying matter, rotting corpses, and the like are often thought to be indicative of a psychotic preoccupation or severe depression. If the patient brings up such a topic, the interviewer should encourage exploration so as to uncover the nature of the preoccupation. Inquiry is also needed to determine that the subject is indeed a preoccupation. Depressed patients may indicate that they once thought of suicide or once had a disturbingly morbid dream, but may have no symptoms of an actual preoccupation. If a patient mentions thoughts of hurting himself or herself or of suicide, the interviewer should prompt a discussion of the issue, since many patients lose their suicidal intent after discussing it in detail — the mystique wears off when discussing the particulars. It is also wise to ask what plans the patient has made for suicide. Carefully worked-out plans and procurement of the means of suicide (such as guns or pills) often indicate serious risk. Patients who talk about friends or family members who "will be sorry" usually intend a suicide attempt rather than death, because they want attention. These are high-risk patients because through miscalculation they are often accidentally successful suicides.

5. **General intellectual evaluation.** Observation of the patient's vocabulary will allow the interviewer to judge whether the patient is below average, average, or above average intellectually. A general rule of thumb used by many clinicians is that the use of three-syllable words indicates average intelligence. Intellectual

level is important in understanding a patient's pathology and how well he or she can be expected to understand it. It is also important for treatment planning. How well can the patient utilize verbally oriented psychotherapy? Would bibliotherapy be useful? Or does the patient need a more concrete, experiential approach? What goals can be set for discharge in terms of self-sufficient living and occupational success?

6. **Insight and Judgment.** Evaluation of insight and judgment is important in determining treatment approach, reality orientation, self-awareness, and self-sufficiency. It is usually thought that patients exhibit insight if they are generally aware of what is wrong with them. Patients who deny apparent problems, project blame or responsibility, or believe that their problems are caused by X-rays from outer space, for example, do not demonstrate insight. Judgment is shown in patients' awareness of what should be done about their problems. The patient who asks to see a doctor because he or she is having hallucinations exhibits good judgment. The patient who talks back to the voices he or she hears rather than seek help does not.

V. Perceptual Disturbances

Any impairment in perception should be noted in detail. It is thought that auditory hallucinations are usually due to functional psychoses, whereas visual or olfactory hallucinations usually stem from organic or chemically induced psychoses (Detre & Jarecki, 1971). Patients withdrawing from drugs may experience auditory hallucinations in the form of sounds or voices, but in contrast to the schizophrenic's hallucinations, these are experienced as externally rather than internally produced (Bilz, 1959). Any aberration in the patient's perception of reality is reason to hypothesize a psychotic process. The interviewer must then take pains to distinguish the type of psychosis, whether functional, drug- or alcohol-induced, or organic. The diagnostic differentiation here is crucial for determination of proper treatment.

VI. Emotional Regulation

1. **Mood and affect.** Identification of the patient's prevailing emotional tone (mood) and the individual expressions of affect must be noted. For example, a male patient might seem predominantly depressed but exhibit anger when describing getting fired from his job. Both verbal and nonverbal cues must be taken into account, for it is rare that patients will directly define what they are feeling. Some patients even deny obvious affect. The interviewer should be observant for mood and affect cues and follow them up with further observations and questions. For example, a female patient whose voice quivers when she describes the death of her father might not directly identify the anger that accompanies the sadness unless the interviewer notices her clenched fists and comments that she appears to be feeling more than sadness.

2. **Subjective and objective evidence.** Both must be noted. Subjective evidence includes direct verbal expressions made by patients ("I feel sad"), which are based on their perception and experience of their own feelings. Objective evidence is that which can be identified by any observer (crying, voice quality, clenched fists) as denoting a particular feeling quality.

3. **Appropriateness.** Affect that is appropriate or inappropriate to the content being discussed is noted. Appropriate affect is observed when, for example, a patient expresses regret that she did not get a job she had particularly wanted. Inappropriate affect is seen when a patient laughs when describing her mother's death. The fact that such behavior is indicative of conflict is precisely the reason for noting it.

4. **Ambivalence.** The presence of two or more conflicting feelings experienced at the same time in relation to the same object (person, place, situation) is noted as ambivalence. For example, a patient states that he loves his father, who is a no-good, despicable bum. It is not ambivalent if the patient says he loves his father and later in the interview states that he hates him. The conflicted feelings must be experienced simultaneously, indicating in this example the patient's indecisiveness regarding his feelings toward his father.

5. **Depersonalization, derealization.** The presence of a perception that one is not real, as if one is outside of and observing oneself (depersonalization), or that one's environment is not real (derealization), is indicative of serious emotional conflicts and is noted in the particular way the patient experiences it.

VII. Volition

A general assessment is made of the patient's ability to willfully direct a course of action and follow it through to completion. Can the patient, for example, hold an eight-hour-a-day job? Is the patient able to express spontaneity and flexibility? These issues are important in diagnosis, treatment planning, and discharge planning.

VIII. Somatic Functions

Disturbances in *sleep, appetite, weight, or sexual functioning* are important because they often signal psychological dysfunction.

It is noted by most clinicians that difficulty in falling asleep is usually indicative of acute dysfunction, and early morning awakening of a chronic dysfunction. The patient who takes more than thirty minutes to fall asleep is probably experiencing a short-term, reactive type of problem. The chronically dysfunctional patient complains that he always wakes up long before the alarm rings. Anxiety and excitement usually accompany difficulty falling asleep, whereas sadness and psychomotor retardation accompany early morning awakening (Detre & Jarecki, 1971). Many professionals find that difficulty in waking up is often a symptom of depression.

Psychiatric difficulties, particularly those that are acute, disturb the ordinary functions of daily living. Appetite disturbances are common, particularly loss of appetite, as are concomitant weight fluctuations. Some patients complain that when they feel depressed, for example, they overeat. When inquiring about appetite and other somatic functions, the interviewer should take care to ask questions in a way that does not lead the patient to an answer. "How is your appetite?" is preferable to "Have you lost your appetite since you have felt depressed?" "Tell me about your sleep" is better than "Do you have trouble falling asleep?" Patients who want to exaggerate or mask illness can easily pick up clues to specific symptoms from leading questions. It is always best to begin questioning in an area of interest by asking a general, nonleading question. More specific questions can be asked later if necessary.

Loss of libido or other sexual disturbances often accompany psychological problems. Most beginning interviewers are more reluctant to explore this area than are their patients. A question such as "How is your sex life?" will introduce the subject if the patient has not done so. Obviously a short answer such as "Fine" tells you nothing, and you must ask further questions. Often this subject is easily raised when the patient is talking about marriage or dating relationships. As with most items on the Mental Status Examination, the interviewer should be flexible, introducing the topic of sexual functioning at any point in the interview that seems most natural.

SUMMARY

The mental health interview is presented in this chapter as a special kind of communication interchange, in which the interviewer must be sensitive not only to what patients say and how they say it, but also to what the interviewer explicitly and implicitly communicates to the patient. In order to accomplish an effective interview, interviewers must determine the purpose of the interview with each interviewee. They must be aware of both interviewer and interviewee factors that affect the course of communication. Consideration must be given to the setting in which the interview takes place, since various environmental characteristics have different effects on the process and content of the interview.

The interview is discussed in three basic sequential stages — beginning, middle, and end — in order to highlight important variables at each phase of the interview. There is also a section concerning the special interview problems presented by the depressed patient, the schizophrenic patient, the manipulative patient, and the seductive patient, and suggestions are made for dealing with each situation. The chapter concludes with a discussion of the Mental Status Examination as a useful tool in various interview situations.

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JOB DEVELOPMENT AND PLACEMENT

JOB DEVELOPMENT AND PLACEMENT

Joseph Marrone, M.Ed.

Job placement and job development are the parts of the rehabilitation process that involve getting people to work and getting them to stay on the job, a particular concern with persons having a psychiatric disability. On one hand, job placement is something to which everyone can relate because everyone has some of his or her own experiences in this area. On the other hand, there is very little magic in this topic. Job development and placement involve a lot of hard work. You hear many experts discuss the same general principles, but when you try to put these principles into practice it still seems hard. With time it may get easier, but it might not stay easy. The focus of this section is on the job placement problems of persons with long term mental illness.

A number of issues arise as special problems with job placement in general, but especially with persons having a psychiatric disability. For example, "How do I know when someone is job ready?" What happens if I am in charge of job placement and I am told that the client is job ready, but I have doubts? What is the specific information concerning social security that might help clients in terms of returning to work? Finally, there is the issue of self-control. This might be called the "Lizzie Borden Syndrome." People are not worried about hallucinations or medication compliance issues with persons with psychiatric disabilities. Instead people worry, "Is this person one of those crazy people who's going to take an ax or shoot someone?" No one, or very few people certainly, explicity says this, but you can often sense their fear.

Effective placement has very few magical techniques or answers. It is a lot of hard work, trial and error, and hypothesis testing. To do effective placement you must focus on the principles behind the activities. Basically, this section introduces these concepts and focuses on answers to specific questions.

There are differing views of the mental health worker's role as an advocate. Some people say, "Isn't it good that the counselor was that involved in advocating for his or her client?" Others might say, "This rehabilitation counselor's crazy! Where did she get the idea of computer programming?" Part of this conflict of ideas has to do with systems and bureaucracies. There are also some underlying reasons why the mental health system's view of clients and their placement differs from that of the vocational rehabilitation system's view, and it is important to understand these reasons. The Resource Manual includes articles in which these issues are addressed. While there are service issues and premises regarding job placement which are important to review, a counselor's values are also an influential factor. It is necessary to be clear about the counselor's values regarding job placement especially with persons who have psychiatric disabilities. S.1

PERSPECTIVES ON THE JOB PLACEMENT PROCESS

Three different perspectives on the job placement process will be covered in the following discussion: client centered, employer centered, and system oriented factors. The client centered aspects of job placement include the teaching of job seeking skills and the operation of job clubs. Also of concern is what you teach a client to say about him or herself -- the issue of passing. Olshansky's article in the Resource Manual discusses passing. If the client is not going to pass, how do you explain the psychiatric disability in ways that an employer can tolerate? How do you provide support to the client and the family concerning this very stressful issue? And, how do you use follow-up as a strategy for prevention, as well as for crisis intervention?

In examining the employer centered point of view, the counselor begins to think about advocacy. In essence, changes in employer attitudes through advocacy lead to an environmental modification for clients with long term mental illness. Marketing is another employer centered aspect of job placement. S.2
Every vocational rehabilitation agency in the country is involved in marketing. S.3
Table 1 lists some basic marketing strategies. S.4
On-the-job training (Table 2) and targeted job tax credits are also employer centered issues. S.5
Another issue is how to deal with employers who say, "I want to hire a handicapped person. Get me somebody in a wheelchair. I don't want one of those crazy people." Addressing this might involve talking to the employer regarding concerns about a specific client as opposed to marketing agency services too broadly.

Table 2

On-the-Job Training Works for the Employer and the Agency

You Get:

- A pre-screened, motivated, skilled worker trained to your own specifications
- Payment for your company's services as a trainer
- Targeted job tax credit from the time the VR payment ends
- Back-up and support services from VR at your request

The Worker Gets:

- A skill
- A job
- A salary

Who Would You Consider For OJT?

If one of our clients is not as fully qualified for a job in your company as other applicants, yet you do believe he or she can learn the skills required on the work site, you may want to consider entering into an OJT arrangement with us.

How Does It Work?

Once you have identified the job in your company and a client of ours suitable for OJT, the rest is simple. You would sit down with one of our staff and the client to agree on what skills need to be taught, who will do the teaching, how it will be done, the amount of time needed for the training (usually less than 6 months), and minimum acceptable standards of performance which will signify successful completion of the training.

You and the VR staff member will also arrange a mutually acceptable payment (in an amount up to a maximum of $22.00 per day over the length of the training) for your company's services.

What Is Your Commitment?

- Provide the training as agreed upon
- Maintain a good faith effort to retain the trainee as a regular employee provided that he or she performs at the level specified in the training agreement.

System or environmental issues might involve the financial incentives under Social Security called 1619A and B or Social Security rules for Impairment Related Work Expenses (IRWE). The essential question is how can clients continue their benefits?

Effective job placement begins with a placement plan for a client that specifically deals with who is doing it, when is it being done, and how is it being done. When counselors set up a plan that describes placement, measurable performance criteria is the section that is often omitted. When you get to placement, the goals tend to be fairly clear, "I want to get a job as a ________." What is almost always neglected, however, is who is responsible for that specific activity. Getting the job is not an activity, it is an outcome. Everybody, whether overtly or covertly, always thinks somebody else is doing it. The client comes in and says, "I thought that was your job." VR counselors have the standard rap, "I can't get you a job. You have to get a job yourself. I can only help." So, in terms of the placement plan, mutual responsibilities are an issue. Transitional employment and supported work will be discussed as a system modification especially useful for placement of persons having psychiatric disability. Where do these techniques fit in terms of the total placement concept?

It is important to keep in mind that we are dealing with clients who have a lot of problems, sometimes the least of which is their disability. These problems may be related to social, economic, or political issues. Billie Holiday said, "You got to have a little love in your life and a little food in your stomach before listening to any damned fool's sermon about how to behave." When we talk about motivation and follow through, we need to remember this idea as a context. Persons who are in human service agencies need to be aware of the full scope of these issues when they think about job placement.

SOME SPECIFIC PROBLEMS OF JOB PLACEMENT

Problem: "My clients with psychiatric disabilities complain that the plans are too slow for them. They don't want to go through the evaluation. They want to get out on a job. Then you don't hear from them for 3 months. Next, you find out that they lost a job."

This is a frequent scenario. A client is frustrated and impatient, so he or she goes out and gets a job, only to lose it in a couple of months. Then he or she calls you up. What comes to mind? Do you say, in your head, "I told him so," or "I wish she hadn't done that"? Or do you say, "Gee, that's good, he worked for three months"? What is your gut reaction? The client has a right to be impatient, and you, too, are impatient because you couldn't help him or her more. What are you calling job readiness? Is job readiness when the client thinks he or she is ready? The counselor might not agree.

Problem: "I've been having problems when I work with a client toward a specific goal. That is, I have to amend the goal several times in the course of my work with the person because of crises or because of a number of other factors that come up. For example, I am now working with a client who has manic depression. We started out with the goal of training because she had all the background necessary to get into a clerical training program. She stayed in the clerical training program at OIC for about 3 months and then she began to have family problems. She lost her public assistance. She has one child and she had babysitting problems. There was nobody else; so she had to drop out. Because of the fact she was in crisis, she was then referred back to her therapist for a period of 2 or 3 months. When she came back to me again, we had to start all over. At that particular point she was not interested in going back to training, feeling it was too stressful. We also felt that she could not go back, so we tried an on-the-job training slot."

This scenario presents the issue of the cyclical nature of the disability. What you have to deal with is the fact that you have a plan going, a crisis occurs, and then you start back at square one. That's tough, but it is one of the key characteristics of a psychiatric disability.

Problem: "Sometimes I have difficulty in terms of selling or marketing the client because of the questions I get regarding the disability. It is easy to get into limitations in terms of physical disability, but not with psychiatric problems."

One of the things we advertise to employers is that we have all this information about our clients, and then, all of a sudden, we become reluctant to disclose some of that information. In this case you are not only in a bind about societal expectations, but also about what your own agency is marketing.

Problem: "I feel that if a client gets a job on his or her own, even if he or she only holds it for 3 months, it says a lot about the client. Whether or not the job was realistic and whether or not the client was complying with a treatment plan can eventually be used in working with the client if he or she comes back to the agency. I think it is a good sign that a client has the where-with-all and the self-esteem, a feeling of self-worth, so he or she can go out and find employment, whether it is realistic or not."

It is fine to say that the way you learn things is to try them, but how do you minimize the disruption of 35 failures? It is one thing to say look what you have learned, but it is still very hard on the ego. Trying shows real strength. The problem is how do you keep that motivation, how do you keep that ego strength?

PREMISES REGARDING PLACEMENT

The premises about placement described in Table 3 relate to a value system, not just to techniques or skills. S.6

Table 3

Premises Regarding Placement

- System vs. individual placement skills
- Interviews generate job offers (1 in 7)
- Myth of the ideal worker
- Advocacy as environmental modification
- Persons with chronic mental illness want to and can work
- Vocational choice as hypothesis testing:
  - Situation specific assessment data
  - Information gathering
  - Not only one correct choice
- Employer relations are a means not an end
- Action + Words = Values

System vs. individual skills. Job placement is much more a function of the system than of individual skills. Simply put, this means that people get jobs based on getting to where jobs are as quickly as possible. In other words, the quicker the client gets to the job openings and the more job openings for which he or she applies, the better the chances of success. There is a much higher degree of success using this strategy than there is in simply learning good job seeking skills. This does not mean that job seeking skills are unimportant. This does not mean that marketing is unimportant. It means that, in terms of designing a system both for your clients and your agency, you need to focus on what is most important. If you had only two clients, you could go out and pound the pavement. When you are talking about a system for yourself, you need to make some choices. One of the choices counselors are encouraged to make is to develop a broad based system. Get people to jobs as quickly as possible rather than doing lots of job seeking skills, lots of job clubs, lots of individual marketing, or lots of visits to employers. This doesn't mean that the other activities are less important. It means that an efficient system generates more success for clients than skills-building per se.

Interviews generate job offers. Interviews are the one aspect of a system that will lead to jobs. This does not necessarily mean sitting down in the personnel office for a formal 45-minute interview; but talking to an employer is what generates jobs. For persons who are disabled,as well as for the general population, roughly every seven to ten job interviews lead to a job. Now for some clients that means 40 interviews, for others that means one. If you follow a vocational rehabilitation system serving several hundred people over a year's time, this statistic holds up fairly well. So your goal should be to get clients job interviews. One of the main implications here is that you err on the side of sending a client to the interview before job readiness is certain. This does not mean that you ignore screening clients. It does mean that there is large gray area which contains those judgment calls. "Now, will I blow this for both the client and the employer if I send someone who's not ready or doesn't do well in the interview? On the other hand, I don't want to keep someone away from an opportunity." Interviews produce jobs.

The father of the job club, psychologist Nathan Azrin, operated on this idea. The belief that interviews produce jobs was the focus of all the job club activities. Azrin based his model on two major premises. First, get people to as many interviews as possible. What you are looking for is an interview not a job. Employers will turn you down for a job; but fewer will turn you down for an interview. The second premise is that clients need a lot of support when seeking jobs and we need to build up a support structure to operate during the difficult time of the job hunt.

Myth of the ideal worker. Hiring often is not done to find an ideal worker or even done in a logical manner. One of the assumptions in traditional job placement training is that if the vocational counselor does his or her homework and the client does the homework of identifying skills and knowing the job, that the hiring process will be logical. You present a neat package to the employer. What employer can argue with that logic? But most of us deal with employers who are not always logical. This does not necessarily mean that they are not good employers. It might mean that they do not have the time, they are not trained in personnel selection, or they are not interested.

We have all probably been employers ourselves from time to time. Have you ever had your house painted or hired a plumber? In one way or another, you have been in the employment business. What you look for when you hire someone, whether it be a plumber, a painter, or a person to sell cookies, is the best person available, not the ideal person. If you have more time, you look for someone who is recommended and can do the job well at an affordable price. It does not matter that there might be 40 better plumbers. You just care that the work gets done well enough for you. When we talk about hiring in the abstract, we must be careful not to create the ideal employment candidate, one who has no limitations. In fact, hiring is not that ideal.

Advocacy as environmental modification. In an average group of clients, about 25% will interview worse than their job skills indicate. Over the last few years, one of the new ideas in rehabilitation has been to view employer advocacy as an environmental modification. Sometimes rather than teaching interviewing skills, we need to find an employer to whom we can say, "Give this person a chance. I will tell you right now he interviews poorly." This, however, is easier said than done. Five years ago most vocational rehabilitation counselors would have said the client was not job ready because of the lack of interviewing skills. The interview was an essential part of the job, and if the client could not interview, then he or she was not job ready.

There are many ways to address the lack of this specific skill. One way to help the client mitigate the effects of a poor interview is to avoid it all together. Any personnel journal will tell you that the employment interview is the least reliable predictor of work performance. Everyone knows that, so why do it? Employers know no better way. They are comfortable with the system and it keeps personnel departments in business. The counselor needs to be aware of these facts. The process is not logical. Maybe it is reasonable to change the expectation of the employer since the interview does not predict much anyway. This might be preferable to constantly putting the client into situations where performance is poor.

Persons with psychiatric disability want to and can work. Counselors need to believe that clients who have chronic mental illness want to and are able to work. If you do not believe this, you are in the wrong line of work. Rehabilitation counselors believe people want to work. Financial disincentives are a real issue, but most people do not decide whether to work based on how much they get from welfare or Social Security.

Vocational choice. The process of job choice or the narrowing down of job options is, in fact, hypothesis testing. It is very natural to go through a narrowing process, but the only way really to learn is to try the job. I asked several vocational rehabilitation counselors how they obtained their jobs. Did they know they could do placement or be rehabilitation counselors? Most of them did not. Even if you have a masters degree in rehabilitation counseling, you do not really know that you can become a successful rehabilitation counselor. Even if you are a rehabilitation counselor, you might not want to work for vocational rehabilitation. So the process of job choice involves experimentation and is not narrowed down to only one right answer. One of the major issues in vocational counseling generally, but especially with persons who have chronic mental illness (who do not have a lot of success, who are scared, who will probably need a lot more support than you or I might) is to convince clients that they are able to choose from alternatives, to test the choice out, to return for further evaluation, and to move ahead. Hypothesis testing is the hardest part of vocational counseling. When a client comes for vocational counseling, he or she wants you to choose something. Then the client wants you to prove that it is the right choice. Job choice is often paralyzing. Most of us experienced this as we finished school. We have the fantasy that our decision is going to put us on a track that we can not get out of for the next fifty years!

Often the focus of the rehabilitation goal is wrong. There is nothing in the rules of the vocational rehabilitation system that prohibits changes in the vocational goal. If you've read the regulations, you know you can amend an IWRP; you can change a vocational goal. But if your supervisor says, "Well, you need some rehabs," this becomes a real issue. We should not hold the client hostage to our values. In fact, we need to develop some preliminary hypothesis testing.

Focusing on one goal at a time makes sense for practical reasons. That, in fact, gives you more flexibility. The more specific you are about a goal and the reasons for it, the more flexibility you have if that doesn't work out. You say, "We went here, and we are moving to the next logical step, here." Sometimes the next step might be to address a different goal not related to the first, but the progression is logical.

On the videotape you see that Sam went through a little bit of this hypothesis testing. Apparently he had come up with the idea of computers. He tested this idea out in his own head, just in passing. So you need to view the process of job choice as a process of elimination and as hypothesis testing. It is not a lot of data gathering that comes up with one choice that is honed in on by the client as the solution to everything. It is very logical and natural for people to change job choices. We all do. We should not hold our clients to different expectations and vocational development processes than those we hold for ourselves.

THE PLACEMENT PLAN

Even though the IWRP is set up to accommodate a placement plan, few people ever actually do it. A placement plan is used to organize your time and structure your own activities, and to make sure that as many people, including the client, are involved, as possible. This one sheet specifies who is going to do what, when, with whom, and when evaluation occurs. Who is going to call how many employers? How many companies are you going to look for in the Yellow Pages? When are you going to meet to discuss this?

The placement plan helps the counselor use the limited time more efficiently. We said this is what we are going to do. What did we do, what didn't we do? Who else can help?

One of the fascinating things that we discovered at our placement unit was that after 6 months the clients, even clients with whom we thought we had done well, were very disappointed in a many of the services. Clients were surprised that they had to compete on interviews with other clients. They said, "I thought you were going to get me a job. I went to an interview and five other people got hired, not me." If we secured an interview or a job by looking in the Yellow Pages and then calling, clients would say, "Well, I could have done that myself. I was expecting something different from you." We realized, however, that we had made some assumptions about how we would go about our business. Both staff and clients needed to be clear about this. So we developed a simple letter regarding what the agency would do in placement, what the client would do, and how we would go about working together. For example, the client was told that we would be using the Yellow Pages or want ads and that he or she would be competing with others from the same agency. Although some counselors believe that only one client should be sent for the job interview, in reality, it is a good idea to show employers that you have a source of potential workers. Also, the process of going for interviews can help to desensitize some anxious clients.

Knowledge about the world of work is over-rated. There are too many jobs out there for anybody to know about all of them. You can start right now and spend the rest of your life, but you still won't know enough about all the jobs that exist. There are certain kinds of jobs, however, that many clients get and it would make sense to know about these. More important than becoming an encyclopedia of knowledge is thinking about the kind of job a client wants to do. What is important to have the client or counselor check out what is involved in the work? You may need to call up employers, for example, and find out if they will hire those with a high school degree or only those who have gone through a certain type of vocational training.

That is the way you get knowledge - with a little bit of a detective approach about some specific vocational choices. It is not a wise use of your time to try to become an expert about many different jobs. That is an impossible task. You should, however, know the difference between the service industry and the manufacturing industry. You should know about federal government employment and some of their basic jobs, and who the big employers are in your area.

Placement planning goes on throughout the rehabilitation process. Rehabilitation counselors often do not make use of employer's reports and the work history as sources of diagnostic information in order to assess a client's job functioning or job readiness. In the initial interview, counselors get more information about the exact medication level than they do about the client's previous job or why the client left. One reason for this is that employers are often reluctant to give counselors information. In spite of this we need to make a concerted effort both to contact previous employers, who are an important source of diagnostic information, and to take a much more thorough work history. This history goes beyond finding out where a client has worked.

The client does not always give functional data. The client may tell the outcome, but not the reasons for the outcome. Was he or she fired for low production or for absenteeism? People think of fired for absenteeism as a specific reason. What is your definition of absenteeism? What do you think is too much absenteeism? I do not know what too much is. I know some employers people who would fire you for being out one day in 6 months. I know others who allow employees to take a day a month and never notice. So even knowing that a persons was fired for absenteeism doesn't reveal the functional data that rehabilitation counselors need in terms of job placement.

Why was Sam fired? He was fired for absenteeism, but no one seemed to have a big problem with his absenteeism. Was his absenteeism different than the person who was fired for being absent the same number of days because he or she decided to sleep late? In this case Sam's absenteeism raised a different issue. When you are assessing a client, know what information is useful in order to help him or her get back to work. However, there are some practical limits to this. I can tell you about counselors I have supervised who would be willing to spend days trying to speak to the psychiatrist who treated their clients three times over 4 years ago. However, these same counselors would assume that because these clients worked a short term job at a hamburger stand 6 months ago it would not be worthwhile to check that out. They would not even give that job experience a second thought.

It is a question of intent and approach. If we are assessing work disability and work readiness, then the most accurate way to measure this is to look at the client's functioning at work. This does not mean he or she cannot change the behavior; but the best assessment data available is previous performance in a similar environment. What is more environmentally specific to a client's role as a worker than to assess the client's capacity to be a worker. I would venture to say that work in a hamburger stand often tells more about a person's work behavior than their functioning at a rehabilitation facility. Even when we do an evaluation and get some good assessment data, no vocational evaluator is going to say that there is an exact match. An evaluator says, "I can give you some information about the person's ability or the person's interests. I can't really give you environmentally specific information about how this person is able to use those abilities, or how that interest is going to play out. You get that from a real work environment."

REHABILITATION AND MENTAL HEALTH PERSPECTIVES

Rehabilitation counselors view work as a means for clients to maintain and regain their health, not as an activity to pursue after health is regained. Now once again, the vocational rehabilitation system imposes some limits on that, but the point is a rehabilitation counselor believes that productivity is important. Sometimes people need to be productive or to feel productive before they are able to comply with treatment. In other words, treatment compliance should not be the prerequisite to getting a job. If you have a history of treatment compliance as the main issue in losing jobs, then that is different. But too often we get into a sequential process that says you need to do this and this before we'll get you a job. Sometimes the client needs to work on feeling productive, whether in a job, in a workshop, or in a supported work experience, before he or she is able to work on other problems. S.7 S.8

The other issue which relates very much to job placement, is that rehabilitation counselor believe in the technique of hypothesis testing. We believe that you gather some data, you try it out in vivo, and then you use what you learn to move ahead. That is different than in traditional medicine where the emphasis is on technology and cure. Our goal is to put safety nets around that hypothesis testing process and help the client obtain data he or she can use to make intelligent choices. Ultimately we ask the client to take some risks. The VR system reinforces the notion that clients go through this process in a nice lockstep fashion, but we all know that does not really happen. It is important to see that the hypothesis testing process is not something we do because we don't know any better; it is something we value as a way clients learn behaviors in real situations. They do not learn behaviors because a counselor sits them down and tells them how to act. Clients learn behaviors and skills by being given information, practicing, and obtaining feedback. Then they move ahead. In this way rehabilitation functions as an adult learning process.

EVALUATING JOB READINESS THROUGH FUNCTIONAL ASSESSMENT

What data do you use to decide if a person is job ready? What kinds of information do you use? Motivation, skill level, attitude, appearance, training -- those are all things you need to know. How did the client act in past jobs? These are all useful, very specific pieces of information. The one thing that they all have in common is that they are all a client's characteristics. In other words, you define work readiness by looking at the set of characteristics the client presents.

You have all probably seen or used work readiness check lists. No one is ever work ready. The lists I've seen describe the classic ideal candidate. Rehabilitation counselors need to think about job readiness as a specific form of functional assessment. Job readiness is a dynamic that basically tries to match the client and the job and the employer. Someone is job ready for a specific job at a specific place of employment. No one is job ready to be a welder, for example. The kind of a welder and the setting need to be defined.

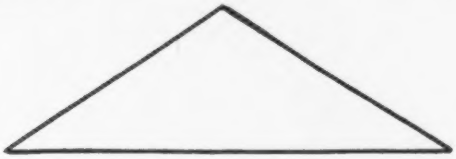
In Washington, D.C., many counselors deal with the federal government. Clients placed in one department and doing a good job could never get hired and could never do the job if they were in another department with another supervisor. So functional assessment in job readiness does not just get data about the client, but also involves collecting data about the employer and the job. In managing your cases it does not make sense to think of a client as job ready unless you have a specific job and a potential employer in mind. You obviously do not know every employer, but you should have a handle on the type of employers in your labor market. Most of our clients have reasonable requests. "I'd like a job - not at minimum wage. I cannot support a family on minimum wage. I need a job with medical benefits." Those are the kinds of things on which we need to focus. And to do this you need to make an assessment of the client, the job, and the employer.

The major categories of this assessment are seen in Figure 1. Job readiness is assessed by looking at the client in terms of his or her abilities, values, and tolerances; by looking at the needs and values of the employer; and by evaluating the job in terms of abilities and tolerances required.

S9

Client

ABILITIES - What can (s)he DO
VALUES - What does (s)he WANT TO DO
TOLERANCES - In what environment can (s)he DO IT



Employer	Job
NEEDS	ABILITIES REQUIRED
VALUES	TOLERANCES REQUIRED

Figure 1. Assessment of Job Readiness.

The client. Ability means what the person can do. We tend to use ability as a positive factor, but I think it is a neutral factor. Ability is a measure of performance in a certain environment. We tend to use the word ability as synonymous with a lot of ability, i.e., as a measure of performance above a certain level of achievement.

Here is an oversimplified case. Suppose someone wanted to be an electronics assembler and is in a sheltered workshop producing at 20% of the norm. Many people would say that the client does not have the ability to be an electronics assembler -- the level of ability is below that required in order to be an electronics assembler. Interestingly enough, most people get placed from sheltered workshop facilities when they produce at about 60 - 70% of the industrial norm. When you establish the competitive norm at 100%, you assume that is where the client has to function in order to get the job. If the client's ability to perform is at 20%, you could then develop a strategy to increase that person's level of ability, either through learning strategies, modeling, motivational techniques, or coercion. The point is at this stage you do not make a judgment that the client does or does not have the ability to be an electronics assembler. You measure the person's ability along a scale and then you work on skill teaching or on behavior modification. Whatever intervention strategy you use, you need to look at measuring ability along a scale and not at defining ability as performance above a certain point.

Rehabilitation counselors need to look at client values as well as client abilities. What does the client want to do? What does he or she say about work? A client has all the skills to be a dishwasher. He or she could get the job but is not interested. Often we tend to negate the importance of client values or to see values only in terms of the problems they create. We say, "If only the client weren't so picky." All the staff in my placement department were complaining about a client with a wife and three children who turned down a job at $4.00 an hour with no benefits. "Who does this guy think he is, what does he expect us to do?" I looked at them and said: "Am I crazy or are you crazy? Since I'm in charge, we're defining it as you're crazy." When they stopped and thought about it they were embarrassed. Rehabilitation counselors have placement pressures as part of their job, but they also need to be very conscious of the client's values and needs. We all have to compromise sometime and that includes clients. However, you need to respect your client's values and factor them in when you assess job readiness.

The employer. Let's move to the needs and values of the employer. Needs are simpler to define. What is the job the employer has available? What is he or she looking for? Employer values deal with attitudes. Some employers do not like disabled people. Some employers do not like black people. Some employers do not like white people. Be aware of the fact that part of the equation of job readiness has to do with the employer, not just with the job. Part of the counselor's job involves working with the employer to change (or soften) his or her values if they interfere with the client's employment chances.

The job. Finally, the specific job is evaluated. One aspect of the job deals with abilities. What kind of skills are needed to be an electronics assembler or a welder? Tolerances identify the kind(s) of environment in which the client can use the skills that he or she has and wants to use. Most of you do not have the luxury of getting an employer to change the office setting. It is important to see not only what the client can do and what the client wants to do, but also what the different environments are in which the client can function. Similar jobs are done in many different environments. You can probably all share stories about your supervisors, "I've got a hard one!"; "I've got someone who lets me do whatever I want!"; "I've got someone I like!", etc. The job is determined by not only the particular skills needed but also by where the job is done. So counselors need to look at job readiness as a dynamic that is situation specific. If somebody asks you if someone is job ready, you say, "For what job? What employer? Be as specific as possible."

Sometimes you do not have all the pieces of the puzzle and that is all right. Our jobs require going on with uncertain knowledge. If you define job readiness totally in the bailiwick of the client, you will be very limiting to your client. You can't change anything about the client's job history or I.Q. You could probably change their way of dressing or possibly their job seeking skills. But to the extent that we focus only on the client, then all the pressure is on him or her and, in a sense, off of us. Once we add the employer and the job to the equation, it gives us more control over job readiness. Job readiness becomes something to work on and it becomes part of a functional assessment.

In summary, there is no such thing as generic job readiness. It is similar to the concept of handicap. Unless you tell me the environment, I cannot say whether John Jones is handicapped. You need data on the environment in which the client is going to function. We need to see the client not as someone who is disabled, but as someone with a work handicap. When you select sources of data in terms of deciding job readiness, you need to make sure that you concentrate on the client, the employer, and the job. We certainly should have information about the client and the job in any assessment, even though to some extent the employer is often an unknown.

Exercise 3: Marketing Sam to an Employer

The following is a role-play exercise that involves practicing marketing strategies:

(C) - Vocational Rehabilitation Counselor
(E) - Employer

(E): Well, what can I do for you today?

(C): Well, first of all, thanks very much for seeing me. I'll only take a few minutes of your time. Basically, what I'm here for is to talk to you about the janitorial positions that you have open and the reason I am here is that I work for an organization who helps employers like yourself recruit for a variety of positions including the janitorial jobs you have open. The way we go about assisting in recruiting is by hooking employers into a pool of qualified applicants that we're involved with. Our goal is to help people who have had some problems in the past in terms of working to get back on their feet, get them the skills they need to go back to work, and help them present those skills to employers. Very specifically, I believe I have a person who fits the bill in terms of the janitorial job that we spoke about.

(E): Can you tell me a little bit more about this person?

(C): Sure, I'd be happy to. He's someone who has over five years janitorial experience in 3 or 4 settings, most recently at a nursing home. He has some specific skill training both in high school and that our organization has helped him to get in terms of basic janitorial skills, in terms of the mopping, the sweeping, the use of the various chemicals and equipment. And he's got very good work references from his previous jobs that I would be happy and he'd be happy to share with you. He's also someone that I've worked with over a fairly long period of time, so I would be able to give you a lot of the good information that I found out about him in terms of his reliability, punctuality, his willingness to work as he demonstrates by showing up to work every day.

(E): Well, I have two questions. He sounds very good but I'm a little concerned. How come he isn't here for an interview on his own?

(C): Well, he would be happy to come in to see you and that's one of the things I had hoped we would be able to arrange. But the reason I'm in is because I know about the openings you have and part of my job is to seek out openings in the community and also to make employers in the community aware of our services. So I thought I'd take the opportunity to introduce myself; but I certainly would like to set up an appointment with you and for him, and I hope we can do that before I leave.

(E): And your agency works with people with disabilities, and I'm a little concerned at this point, over what his disability might be.

(C): Well, we work with people who have a variety of problems, whether it's medical, learning, psychiatric, whatever, whose problems have interfered with their working. What our services primarily do is to help people get the help they need to get back to working and get back to the stage where they were. I certainly have some constraints in terms of confidentiality of information as I'm sure you can appreciate from your position. However, this particular person is someone who I've known for 2 1/2 years who had had some problems that had affected his job relating to the time he was getting divorced. He had, as you can well imagine, some problems in terms of dealing with his family issues. However, one of the things we've worked on is getting him back on his feet. He's worked very hard on working things out for himself. He's demonstrated his ability to get back to work, to get some additional training. Many of the situations I've seen him in have required him to show up for work every day, to show up for appointments with me on a regular basis and all the contexts I've seen him in show him to be very reliable, show him to be very punctual. So he's someone simply who has had some problems and we've helped him in terms of the work he's had to do to put them behind him.

(E): Well, that sounds pretty good. I think that one of the problems that we have when we are thinking about people for these positions in the janitorial department is that I need to tell the supervisor that somebody is going to be pretty reliable. I've had some problems with the supervisors, because there have been people who have been incredibly incompetent or who have had various problems and have not shown up after a week or two on the job. With somebody I recommend to be interviewed by the supervisor, I like to feel that this person really has a good job background and that they sound pretty reliable.

(C): Well, this person fits the bill. Certainly reliability is one of the key things in any employee that I am sure that you look for and frankly, that I look for. One of the things that I'm very pleased about with Sam Smith is the fact that I can really tell you in very specific terms, once again, about his reliability in showing up for work on time and his ability to follow through on instructions in all situations where I've had first hand knowledge. Also, I've been able to review his references so I would be very happy to vouch for them as well.

(E): One thing I do want to say, I realize that a lot of this is confidential. But we've had some problems in the past with people on medication, psychiatric problems, and I don't know whether you can tell me this straight out, whether or not this client is on some kind of medication, or that he's being followed, if he is, because that has been a problem in the past. I'll be honest with you, we've had some problems with some of our employees before.

(C): What kind of problems have come up around that?

(E): Well, some people have been taking the medication, you know, and then they stop taking it for one reason or another, and then don't show up for work or get very abusive when they were on the job, and there's been a number of problems with that.

(C): Sam has had no problem at all in terms of showing up for work, in terms of, once again, following through on any instructions, in terms of completing training well. I will tell you even though as you mentioned it's a sensitive area, that he has sought out the help he's needed. In terms of any of the problems you've mentioned, it's not a problem that Sam has and I would have no problem recommending him, in terms of the job. It certainly hasn't come up in the situations that you talked about.

(E): Okay, okay. Anything you would like to ask me about the position?

(C): Well, I would like to know some more specifics. I read the job description and certainly don't have to waste your time going over that again but I wonder if you could give me some more specifics in terms of the particular work environment, the size of the work crew he would be working with, the hours.

(E): Well, as you know, it's a general janitorial position and it's a dayshift. It's from 8:00 to 4:00 and he actually would be working fairly independently, even though he's officially on a team. Very often people do work independently cleaning restrooms and doing just general sweeping and mopping, so he would be working independently.

(C): Well, that's good.

(E): Can he work independently?

(C): Certainly, part of the specific training that we've helped him arrange for himself and part of what we try to focus on, (many of our people are trying to help companies recruit) is that need, because a lot of jobs require following instructions but being able to carry them out independently, and Sam is one of the people who has been able to demonstrate that ability. I'm sure he would fit your particular need very well. So he wouldn't have to have a supervisor standing over him at all times, giving him instructions - he can follow things through. No, certainly, not so much because of Sam but because of your particular needs, I would assume that the supervisor in terms of the initial training would really want to make very clear to any employee, including Sam, what the particular needs are and what would be demonstrated to the supervisor and to the employee himself, that he was doing the job very well. But if the supervisor were able to demonstrate that, as I'm sure he's had to do with other employees, I think Sam is very good about following through. Certainly if it's a particular issue in terms of communicating certain kinds of information, one of the areas of expertise I have and our organization has, is helping work-site supervisors, who might not be very familiar in terms of personnel terms, in breaking down the instructions to a job in ways that are easier for people to understand, but Sam has demonstrated that ability before.

(E): If there were any problems, once, we were ready to hire Sam for a company, what could we do? Could we call you in as his counselor to come trouble-shoot a little bit?

(C): Well, first of all, I should state that based on my experience, I wouldn't expect any problems beyond the natural problems that occur with any new

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employee. But if something came up that you were having a problem with, that you thought I could be helpful, feel free to give me a call. I would be happy to come right out. One of the things I would be doing normally with any of the people we help companies recruit is checking in with them over several months after they get a job to make sure things are working out okay. If you would, or the supervisor would appreciate, I would be very happy to not just check in with Sam but also with the supervisor to see if there is anything I can do. It would really be up to the supervisor.

(E): Basically, he would be working fairly independently, but he is part of a team too. How well does he work with other people? As part of his day, he'd be working with some other crew members, how is he?

(C): Sure, I understand that. Well, his previous jobs, in terms of the nursing home, and in terms of Woolworth's, have involved working in a variety of settings. Sometimes he's about the only person responsible for a floor, so he's shown no problems in either area. I'd say in looking at my own particular experience with him, certainly he's had to work with me in a team format, obviously different than what you're looking at, but he's certainly very cooperative, part of the training that we've helped him arrange for himself involves group training and group instruction in terms of janitorial work. He's, once again, performed very well, gotten very good evaluations, has gotten along very well with both his coworkers and his supervisors, so I expect that translates very well to your job.

(E): Okay, I think that's pretty much about it. The only other thing, and this is kind of a minor issue, that we've found some problems in, is that very often a lot of our people work in the janitorial department, we're kind of off the beaten track when it comes to public transportation. Any plans made on how Sam would get here? Does he have a car?

(C): Right now, Sam takes public transportation; but one of the things that once again that we assist people with is some help in terms of paying for transportation. I've researched it myself. You're certainly not right on the line, but Sam has commuted to jobs that have involved longer commutes, and longer walks from the bus stop and Sam would be very happy to do this and he's told me he's interested. Once again he's demonstrated his interests and I'm sure you'll see that when you meet him. In the future, once he gets on his financial feet again, then he'd be able to go buy an auto. He does have a driver's license.

(E): Great! I have another appointment right now and Sam sounds like a pretty good candidate and I would like to refer him to our supervisor in the janitorial department.

(C): Excellent, would I be able to make that appointment now or should I call the supervisor?

(E): Why don't you call the supervisor directly? I'll talk to the supervisor this afternoon and maybe you can give him a call tomorrow morning. Give him a call between 9:00 and 9:30. Well, thank you for coming in.

(C): Thank you for your time, Ms. Walsh.

Exercise 4: Interview Situations: Practice in Job Seeking Skills

Look over these example responses to hypothetical employer questions. Following each response is a rating and an indication of the response representing passing or full disclosure. Think of other ways to answer these questions.

1. **Why did you leave your last job?**

a. I didn't get along with my boss at all. He expected way too much of me and when I tried to complain about it he told me to leave. (Poor)

b. I didn't make a good job choice. It turned out to involve things I wasn't good at or even qualified to do. I was asked to leave and I understood. I wasn't happy in the job and I've never had that kind of trouble in previous jobs. If you check my references I think you'll find I'm qualified for this job and I was always productive in my other work. (Good, Passing)

c. At the time of my last job, I was dealing with a lot of problems around the break-up of my marriage. My work suffered and the company had no choice but to let me go. I did seek out help and I worked through the bad times. I think if you check with my employers before that point, you'll see my work record is very satisfactory. You don't have to worry about that problem getting in my way again. (Good, Full Disclosure)

2. **Looking at your work record, I see you haven't worked in the last 2 years. What have you been doing during that time?**

a. Well, I was sick so I had to go to the hospital but now my doctor says it's okay for me to work again. (Poor)

b. Well, to be honest with you I was having some family problems at home that were really affecting my job. Rather than let that go on, I decided I had to take care of one thing at a time. I sought some counseling help and with a lot of hard work I was able to resolve the problems. Now I really believe I'm ready to go back to work. For the past couple of months, I've been doing some volunteer work just to make sure of myself but I know now I can give 100% to this job. (Good, Full Disclosure)

3. **Have you ever been hospitalized for any physical or mental illness?**

a. That's none of your business. I know my rights. I don't have to answer that. (Poor)

b. I certainly don't have any problems that would interfere with my ability to do this job now, but I don't see how that specific question relates to the job. Could you tell me how it does? (Good)

4. **Why have you held so many jobs?**

a. Well, I went through a divorce. I was very depressed and my parents had to get me hospitalized a few times but the doctor says I'm okay now. (Poor)

b. I had a series of jobs at the same time I was going through a divorce. I found I kept going back to work without resolving that problem. Now I've worked on the problem, I've resolved it, and I'm currently working in a special program for people who have had these kind of problems before. You can check the high quality of my work with this employer. (Good, Full Disclosure)

c. Well, to tell you the truth, most of the jobs I had, my bosses weren't patient enough with me. You know, some people expect an awful lot from minimum wage jobs these days. (Poor, Passing)

d. Well, I wasn't sure what job area that I wanted to stick with and I thought the best way to explore possibilities was to try things out. I want to make it clear that I left all of my jobs with adequate notice and often I was one of the employees who had the longest time on the job there. (Good, Passing)

5. **Why do you feel you're ready to work now?**

a. Well, I've been evaluated as part of a program that works with people like me. My doctor and my counselor think it's okay. (Poor)

b. Well, I've worked very hard over the last two years on developing the skills I need to handle this job. I got more training in janitorial work. I worked a minimum of 20 hours a week for the last 6 months and worked without being late or missing a day and my supervisor there would be happy to provide you with a complete work reference. I've sought out help when I needed to and I've learned how to get assistance quickly when I need it before my problems get too much for me to handle. (Good)

6. **Why were you in the hospital?**

a. Well, you wouldn't believe the kinds of problems I had. Everyone thought it would be a good idea for me at the time. (Poor)

b. Well, I had problems dealing with the divorce from my wife but I decided to seek help. I got it and now I've demonstrated by being active in my rehabilitation program that I can tackle work again. I really look forward to showing you I can do that job. (Good)

7. **This job involves a lot of stress. Would this be a problem for you?**
a. I don't think so. What kinds of stress? I'll give anything a shot. (Poor)

b. Not at all. I worked very hard in controlling my emotions well and I've succeeded. I've demonstrated by the work I've done on a daily basis in my rehabilitation program and the effort I expended to get myself back to being able to work that I can handle large amounts of stress. Feel free to check any of my references on this point. (Good)

8. **Well, we work as a team here. I wonder how well you'd work with other people.**

a. Well, as long as everyone is patient and understanding, I don't see any problems. (Poor)

b. Well, actually, I really enjoy working on a team and all of my other jobs have involved sharing tasks with the other employees. In fact, that's one reason that attracted me to your company. Also, I had to put in a lot of hard work with lots of different people to get myself back to where I am today. I can put what I've learned in that area to good use when I become part of your team. (Good)

SESSION GOALS:

1. VALUES
2. NEED FOR ADVOCACY
3. RISK-TAKING ON CLIENT BEHALF
4. SYSTEM > SKILLS
5. PRACTICAL TIPS
6. PROMOTE DISCUSSION
7. ENGAGE "TOUGH" QUESTIONS - SPECIFIC CASES
8. EDUCATE REGARDING THE REALITIES OF MOST HIRING PROCESSES
9. YOUR CLIENTS ARE NOT SO BAD
10. NO "MAGIC"
11. CONTROL WHAT YOU CAN - DON'T SWEAT THE REST

COMMON QUESTIONS:

1. "THE WHOLE TRUTH"?
2. IF TRUTH, HOW TO PRESENT IT?
3. ECONOMIC DISINCENTIVES?
4. MOTIVATION?
5. ATTENDANCE/PUNCTUALITY?
6. JOB READINESS?

7. THE "HOPELESS CASE" - CAN YOU TOP THIS?
8. HOW MUCH TO TELL SUPERVISORS/CO-WORKERS?
9. HOW TO COUNTER EMPLOYER OBJECTIONS DUE TO:
    - a) POOR AGENCY HISTORY?
    - b) POOR EXPERIENCE WITH A PARTICULAR CLIENT?
    - c) POOR EXPERIENCE WITH A PARTICULAR PSYCHIATRIC DISABILITY?

10. JOB SEEKING SKILLS?
11. STRESS?
12. GETTING ALONG WITH OTHERS?
13. HOW TO EXPLAIN WORKSHOP, TE, SE?
14. UNREALISTIC GOALS?
15. HOW TO DEAL WITH LOSS OF SUPPORT?

PREMISES REGARDING PLACEMENT

- PERSONS WITH CHRONIC MENTAL ILLNESS WANT TO WORK.
- PERSONS WITH CHRONIC MENTAL ILLNESS CAN WORK.
- JOB READINESS IS DYNAMIC; ON A CONTINUUM.
- VOCATIONAL CHOICE AS HYPOTHESIS TESTING.
  - SITUATION SPECIFIC ASSESSMENT DATA
  - INFORMATION GATHERING
  - NOT ONLY ONE CORRECT CHOICE
- INTERVIEWS GENERATE JOB OFFERS (1 IN 7).
- MYTH OF THE IDEAL WORKER.
- EMPLOYER RELATIONS ARE A MEANS NOT AN END.
- ACTION + WORDS = VALUES

REHABILITATION PRINCIPLES

- PRODUCTIVITY IMPORTANT TO PHYSICAL AND MENTAL WELL BEING
- PERSONAL CONTROL AND RESPONSIBILITY (ONCE GIVEN MEANINGFUL OPTIONS)
- PLATEAUS
- PERSON AND ENVIRONMENT
- HOPE AND SUPPORT

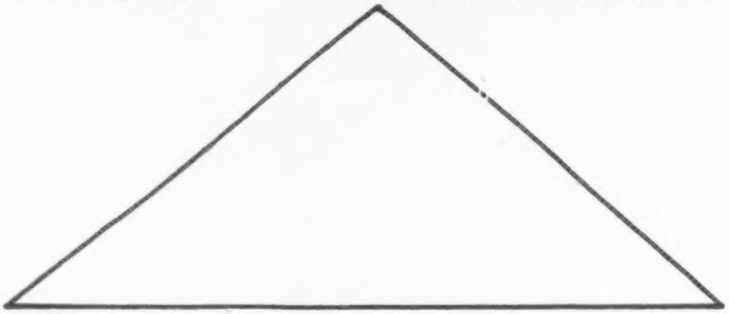
ASSESSMENT AND JOB READINESS

CLIENT

ABILITIES - WHAT CAN (S)HE DO

VALUES - WHAT DOES (S)HE WANT TO DO

TOLERANCES - IN WHAT ENVIRONMENT CAN (S)HE DO IT



EMPLOYER

NEEDS

VALUES

JOB

ABILITIES

TOLERANCES

CLIENT-CENTERED APPROACHES

1. SCREEN IN, NOT OUT

2. SUPPORTS

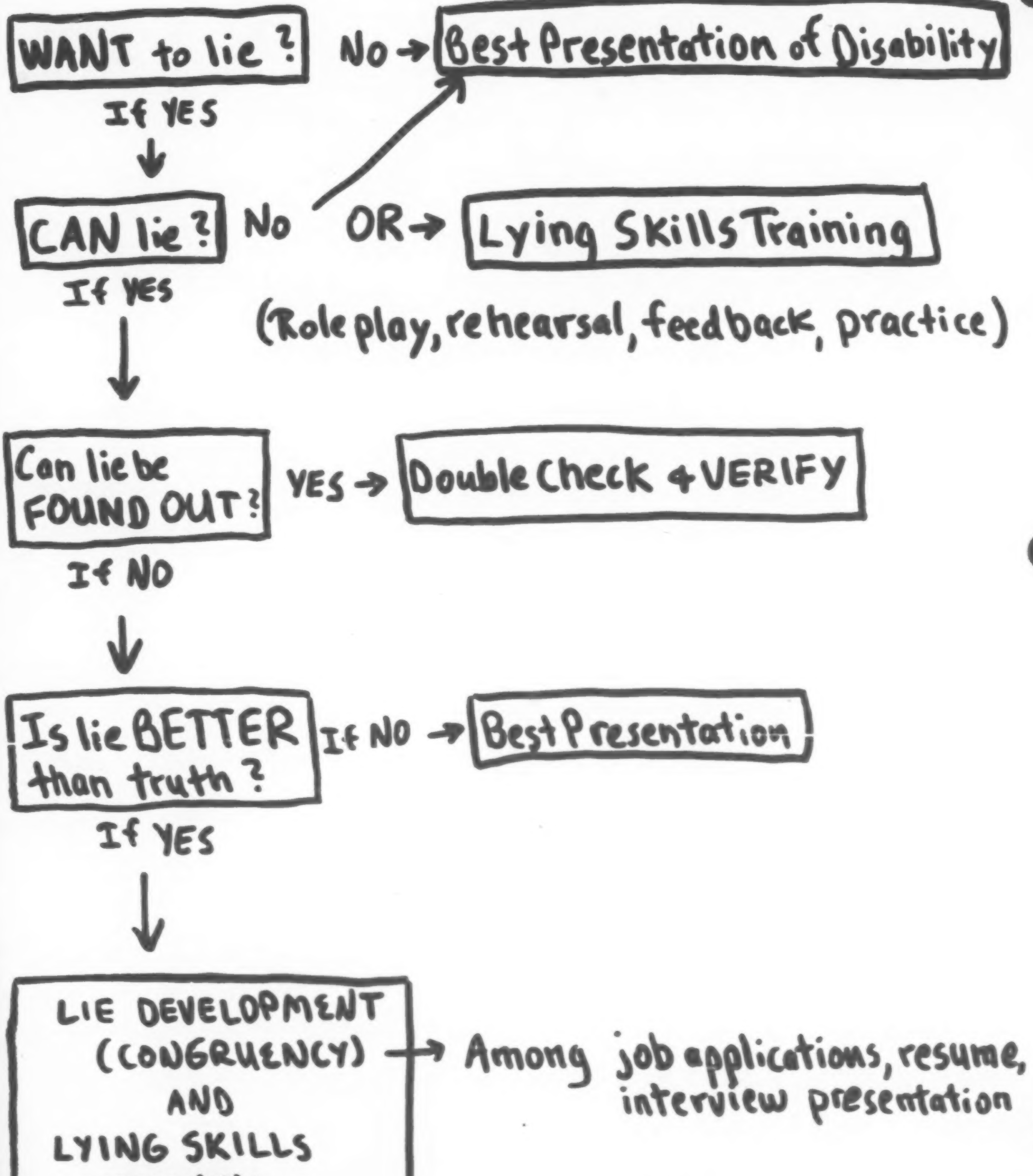
3. JSS-JOB CLUB, PLUS

    - PRE-WRITTEN APPLICATION
    - LIST OF 3-5 ASSETS
    - DON'T VOLUNTEER NEGATIVE INFORMATION
    - "YES, BUT. . ."
    - STRESS CONTROL - 1ST PERSON & ACTIVE VERBS
    - PAST PROBLEMS VS. PRESENT CAPABILITY
    - FOLLOW-UP PHONE CALL

4. "PASSING" VS. "OPEN"

5. PREVENTIVE FOLLOW-UP

LYING DECISION TREE


WANT to lie ?
No →
Best Presentation of Disability
If YES
CAN lie ?
No
OR →
Lying Skills Training
(Role play, rehearsal, feedback, practice)
If YES
Can lie be FOUND OUT ?
YES →
Double Check & VERIFY
If NO
Is lie BETTER than truth ?
If NO →
Best Presentation
If YES
LIE DEVELOPMENT (CONGRUENCY) AND LYING SKILLS TRAINING
→ Among job applications, resume, interview presentation

DEALING WITH A PSYCHIATRIC DISABILITY

- STRESS POSITIVE ASPECTS OF CURRENT FUNCTIONING
- DON'T VOLUNTEER NEGATIVE INFORMATION
- AVOID MEDICAL TERMS OR JARGON
- CONNECT DISABILITY WITH SIGNIFICANT LIFE EVENT
- DESCRIBE CLIENT IN TERMS OF QUALIFICATIONS FOR JOB, NOT DISABILITY
- STRESS CLIENT'S CONTROL
- PAST PROBLEM VS. PRESENT CAPABILITY
- CLIENT PATHOLOGY ≠ CLIENT WORK SKILLS

ON-THE-JOB TRAINING WORKS FOR US AND YOU

YOU GET:

- A PRE-SCREENED MOTIVATED SKILLED WORKER TRAINED TO YOUR OWN SPECIFICATIONS
- PAYMENT FOR YOUR COMPANY'S SERVICES AS A TRAINER
- TARGETED JOB TAX CREDIT FROM THE TIME THE OVR PAYMENT ENDS
- BACK-UP AND SUPPORT SERVICES FROM OVR AT YOUR REQUEST

HELPFUL HINTS FOR MORE EFFECTIVE PLACEMENT

1. STRESS KNOWLEDGE OF CLIENT, BOTH WORK SKILLS AND PERSONAL QUALITIES.
2. SUPPORT AND FOLLOW-UP AVAILABLE TO EMPLOYER AS WELL AS CLIENT.
3. TALK UP "PERSONAL SERVICE" -- FREE RECRUITMENT AND SCREENING.
4. ASK HOW EMPLOYER USUALLY HIRES PEOPLE.
5. DOES THE EMPLOYER PROVIDE ON-THE-JOB TRAINING?
6. FIND OUT EMPLOYER'S NEEDS IN TERMS OF HARD-TO-FILL JOBS, HARD-TO-FIND PEOPLE.
7. STRESS PLACEMENT SUCCESSES. DESCRIBE OTHER CLIENT SUCCESSES.
8. ASK EMPLOYERS ABOUT AFFIRMATIVE ACTION CONCERNS.
9. STRESS CONTINUOUS CONTACT WITH AND COMPREHENSIVE KNOWLEDGE OF CONSUMERS AND CONSUMER-ORIENTED ORGANIZATIONS.
10. MENTION OTHER WORK PROGRAMS AVAILABLE-OJT, TEP, SUPPORTED EMPLOYMENT.
11. MENTION TARGETED JOBS TAX CREDIT.
12. ASK FOR REFERRALS AND PERMISSION TO USE EMPLOYER AS A REFERENCE.
13. ADVERTISE YOUR PRODUCT - BROCHURES, MEDIA.
14. BE WHERE THE EMPLOYERS ARE.
15. CONTACT LOCAL CIVIC ORGANIZATIONS.

SOME SPECIAL CHARACTERISTICS OF SE PROGRAMS FOR PEOPLE WITH SEVERE PSYCHIATRIC DISABILITIES

1. THE ISSUE OF STIGMA WITH THE ATTENDANT GREATER NEED FOR EMPLOYER ADVOCACY.
2. THERE IS OFTEN PERSONAL DISCOMFORT ON THE PART OF THE PROVIDER STAFF.
3. PEOPLE WITH PSYCHIATRIC DISABILITIES PROBABLY HAVE A GREATER SENSE OF LOST POTENTIAL.
4. GREATER WORRY ABOUT LABELING.
5. PARENT EXPECTATIONS CAUSED BY GUILT AND SOCIAL STIGMA.

QUALITY SERVICES IN SE FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

1. INTEGRATION AND VISIBILITY
2. NON-STIGMATIZING SUPPORT
3. PREVENTION, NOT REMEDIATION, IS THE KEY.
4. COMPREHENSIVE INVOLVEMENT WITH PROVIDER FOR OTHER THAN SE.
5. REHAB PLANNING IS COMPREHENSIVE IN NATURE.
6. COOPERATION AMONG SERVICE PROVIDERS.
7. ACTIVE INVOLVEMENT OF CLIENT AND SIGNIFICANT OTHERS.
8. OPPORTUNITY FOR CAREER MOBILITY.
9. PROGRAM CLIENTS ARE THE PRIMARY CONSTITUENCY OF THE SE PROGRAM, NOT THE EMPLOYER.
10. ZERO REJECT - EASY IN AND OUT
11. OPPORTUNITY TO OPT OUT OF THE "FAST TRACK"

EFFECTIVE COLLABORATION BETWEEN VR AND MH

A. TEAMWORK - WHAT IS IT?

B. ELEMENTS OF EFFECTIVE COLLABORATION AMONG AGENCIES

1. JOINT LEARNING
2. NETWORKING
3. AVOIDING TURF ISSUES
4. VALUING MULTIPLE RESOURCES
5. ACCEPTING AMBIGUITY
6. SHARED RISK TAKING
7. CLIENT GAINS, NOT THE RELATIONSHIP ITSELF IS IMPORTANT
8. RELATE TO PEOPLE, NOT AGENCY
9. DEFINING WHOSE NEED IS BEING MET
10. APPROPRIATE VS. INAPPROPRIATE CLIENTS, "READINESS"

GOAL: To Help the Trainees Gain An Appreciation Of What Line Staff In Each Agency Have To Deal With As Part Of Their Internal System Structures

VIII WHAT DMH CASE MANAGERS SHOULD KNOW ABOUT VR AND VICE VERSA

A. ABOUT VR

1) The VR system is based on eligibility. Eligibility for VR services involves access to the professional services of a VR counselor for the purposes of vocational planning. The counselor has resources at his/her disposal to provide or pay for services. However, simply put, being eligible for VR does not mean the counselor agrees to provide any specific services except counseling and placement.

2) The VR system is vocationally focused. This does not mean that the only services provided are vocational ones, but rather that every service requested has to be judged on the basis of whether it will aid in the achievement of that client's vocational goal.

3) VR services are individually based. Even though there is a tendency in VR systems, as with all large systems, to make clients fit the system, not the other way around. But the core of the VR model is that the client is entitled to an individual program of services, based on his/her unique needs. In fact, the much maligned IWRP is the legislative prototype predating the other federal/state alphabet soup designations such as IEP, ICSP, IHP, etc.

4) VR service funding is client-driven, not system/slot driven. This is a bit of an overstatement but nonetheless, the premise of most VR service delivery is the identification of individual client needs which are provided through individual purchase of service funds. This is very different from the way most MH & DMR services are provided. Adding pressure to this purchase system is the practice of MRS counselors handling individual caseload budgets.

5) VR services have always been closure and outcome focused (i.e. the most important goal measured is job placement). Even more so now, with the introduction of the MCS system which gives different weights to various types of employment outcomes for different types of people. DMH day services nationwide have historically been concerned more with dispositions and clients served than specific successful outcomes. VR counselors feel regular pressure to achieve their goals, which itself is not problematic. However, what tends to happen is problems in achievement often get addressed by changing the client mix (i.e. more "appropriate" clients) rather than improving indiividual skills or modifying the system.

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6) The VR system as a whole has been under great stress nationwide over the last few years. What for many years has been a small, non-controversial, stable, self-contained service network has been under greater scrutiny than ever before. There are questions about whether the VR model is useful for severely psychiatrically and developmentally disabled clients. Whether VR should broaden its scope or leave vocational services for such people to DMH and DMR? Whether Supported Employment will dilute the clear vocational focus that has been in place for 60 years? Whether S.E. should be an allowable VR service (Title 110 funds) or separately delivered through Title VIC funds? The residual tremors from these tensions are felt to some extent by every level of VR staff.

B. ABOUT DMH

1) DMH (Rule 74) has eligibility criteria also, but these criteria are based on categorical definitions which are much less susceptible to individual DMH Case Manager judgement than VR eligibility criteria are to VR counselor judgement. The variability from VR office to office, VR counselor to counselor, which often frustrates outsiders is a sign of this flexibility. VR counselors used to making these sorts of determination get frustrated by case management staff who insist they have little control over the eligibility determination process.

2) DMH systems have always had a more "cradle to grave" focus on service delivery. And, especially since the advent of the CSP movement, they have not had the luxury of focusing on just one type of service need. Residential, treatment, advocacy and protection, and vocational services all fall somewhere within the current DMH case management purview. Therefore, it is difficult for DMH case managers to develop a specific area of expertise, beyond the generic one of "case management", given the wide range of client needs to which they must attend. When VR people are "stumped" on vocational options, DMH case managers often then feel without allies in this regard.

3) Historically, most DMH day service delivery, because it has served broader needs and been of a much larger scale than VR, has been purchased on a contractual basis. Generally, a certain number of slots (or FTE's) have been agreed upon with a program provider and when these slots were filled, a waiting list was developed,. Also, many times, service providers have been able to control entry into DMH contracted day slots: whereas most often in VR service delivery, referrals come from the VR counselor to the service provider. The magnitude and scope of DMH service delivery cannot be overemphasized as a

crucial factor in system tendencies. DMH has had to ensure that certain types of mandated services (in-patient, day treatment, emergency services) are available to a vast array of people with mental health needs. This system focus has often led to categorical dispositions (certain kinds of people need certain services) rather than individual planning and program development).

4) Because of the vagaries of the concept of mental illness and the lack of clearly effective treatment strategies, the provision of DMH services has tended to be more process and problem focused than based on successful interventions. Much disagreement exists even within the mental health field itself as to what works. There has also been much societal pressure to make sure that mentally ill people do not pose either danger or embarrassment to themselves or others. These widely disparate problems and controversies have led to the development of a large, sometimes unwieldly, amorphous service system which spends much more time attending to client problems than on solving them. This is not an indictment of the staff but rather a reflection of the political and social realities which all mental health systems live under. There is an expectation that VR services will produce successful employment outcomes; there is no expectation that DMH services will "cure" mental illness.

5) Some of the stresses the DMH system has been under, nationwide and locally, parallel that of the VR agency. They have been asked to focus more time and attention on those people with severe and persistent mental illness (i.e. severely disabled people). DMH staff have been asked to expand their capacity to affect people's lives by delivering other than traditional mental health treatment services (e.g. vocational services). DMH and VR staff have both been given overlapping mandates in the employment arena - a situation which provides a safety net for clients but causes a great deal of uncertainity in the minds of staff. In addition, DMH staff are part of a more visible, more politically charged, larger service network than VR staff. They are often subject to public policy pressures (national/state magazine cover stories on deinstitutionalization, homeless people, "violent ex-mental patients", etc.) that most VR staff are immune from due to the fact that VR agencies are smaller, deal with less sensational problems, and have a tighter focus.

GOAL: To Assist Trainees In Gaining An Understanding Of The Essential Components Of Effective Teamwork Between V.R. & M.H.

VII EFFECTIVE COLLABORATION BETWEEN V.R. & M.H.

A TEAMWORK - WHAT IS IT?

- Effective collaboration between systems involves the concept of teamwork. A definition of teamwork offered here has been developed by Naomi Brill:

> A team is a group of people, each of whom possess particular expertise: each of whom is responsible for making individual decisions: who, together, hold a common purpose: who meet together to communicate, collaborate and consolidate knowledge from which plans are made, actions determined and future decisions implemented."

- A rehab team must include the client and significant others as an integral pact of the team.

- Teaming up should not be a way to avoid individual responsibility, delay action or stake out agency turf.

- It should be a way to bring multiple resources to bear on client problems, gain fresh perspectives and ensure clear communication among all parties involved.

B ELEMENTS OF EFFECTIVE COLLABORATION AMONG AGENCIES

1) Joint Learning - There is rarely one single reservoir of expertise available, particularly in the field of S.E. for people with severe psychiatric disabilities. While some people do have greater skills and knowledge than others in various areas, there should be an expectation that VR-MH collaboration around S.E. will result in both organizations needing to (re)learn different ways of thinking about severely psychiatrically disabled clients.

2) Networking - Collaboration by definition involves a network among the team members. However, related to Number 1 above, is the need to expand the knowledge base available in the team by reaching out to people and entities that could shed some light on ways of dealing with thorny client and/or system issues. This expanded network may include providers, consumers, similar service systems, university-based TA, etc.

3) Avoiding Turf Issues - A third element of effective teamwork is the need to avoid turf issues. Turf issues are defined here as issues related to maintaining the system status quo and avoiding any change in one's own operations. Positive collaboration involves identifying client related problems that need to be addressed and finding ways to ensure that one's own agency can assist in this endeavor, not look for ways out of the effort. Differing mandates are very real but there is much flexibility built into the VR law as well as Rule 74 for counselors and case managers to find resources to become more, not less involved.

4) Valuing Multiple Resources - There is built in overlap amoung many legislative mandates as noted above. While very real issues abound in the funding arena (Who's going to pay for what client and for how long?), there are other needs which people entering SE often have (housing, public assistance advocacy, clinical changes necessitated by a work schedule, etc.). An effective team values many of the services team members bring to the problem resolution (knowledge, skills, time, energy, as well as money).

In the realm of DMH - VR collaboration around SE, both VR and MH staff bring personal/professional resources to the meeting table. VR people should bring a perspective on individual vocational development, a knowledge of the vocational services system and experience in case management with clients working out individual service plans. DMH Case Managers should bring extensive knowledge of serious mental illness, a broad based overview of non-vocational parts of the human service delivery system (e.g. residential or treatment options) and presumably a closer working relationship with the total array of DMH caregivers offering assistance to the client.

5) Accepting Ambiguity - There are many unanswered questions about S.E. for severely psychiatrically disabled people as well as VR counselors' and DMH Case Managers role' in the process. Added to this mix is a large amount of role overlap and differing pressures from each system on its own staff (for DMH Case Managers—the pressures of the ICSP and Rule 74); (for VR Counselors-the pressures of the IWRP and the MCS). Finally, the problems that many clients bring to their SE placement are not often easily resolvable. No one can work effectively as part of a team if that person expects clear answers to all the questions about roles, funding and client needs, before feeling comfortable in moving ahead.

6) Shared Risk Taking - Related to Number 5 above, both DMH and VR staff must understand that the collaborative efforts are a form of shared risk taking. When roles cannot be clearly defined or client problems solved completely, there is a tendency to want to point fingers. Collaboration means sharing the risks, sharing the problems and sharing the rewards. An effective team effort will allow each of the members to take on some risks (i.e. flexible eligibility decisions, extended funding, extra work) but will also provide a vehicle for maintaining a tolerable amount of stress on any one person's particular job duties.

7) Client Gains, Not the Relationship Itself Is Important - There is no magic in a good relationship developed among service providers. People must keep the goal of better services to our clients in mind. Effective teamwork is precluded by bickering and personal animosity amoung team members. However, all too often good relationships among professionals are developed at the expense of client goals.

Our clients want services that challenge our capacity to deliver them. Both VR & MH staff work under a layer of bureauracy that generally reinforces "safe" decisions. VR counselors and DMH case managers probably all have too many clients and too little time in the day. If the premium is on good relationships, not client service, there is a tendency to not want to put your peer in a difficult spot - not want to push him/her too much. There can be a desire to avoid testing the relationship by working with clients who are considered marginal in one or both systems. Advocacy is sometimes considered "bad form" and a reflection of not understanding the other person's needs. The test of an effective inter-agency collaborative relationship is services being delivered to people formerly excluded, not the collegial relationship flourishing, per se. A good professional relationship will stand the stress of such tensions just as a solid personal one will.

8) Relate to People, Not Agency - Having stated Number 7 above because it is often omitted in discussions of the subject, I will need to state my belief that a well-functioning team is built on relationships among people, not agencies. This concept is equally valid for engaging the client as an active member of the rehab team as well as for working with other professionals. In the case of client involvement, VR & DMH staff must develop a personal identity in the client's mind set, not totally dependent on that staff's professional function (i.e. some one must be seen as John or Mary - not just as the "DMH man" or the "VR lady"). The way to accomplish this engagement in the early stage is to opt for frequency of contact over length (i.e. a 1/2 hour visit to a program weekly is preferable to a whole day spent monthly).

With regard to personal relations among professional team members, time needs to be spent on niceties often considered extraneous to the important business at hand. Habits like always rushing in late (or out early) of group meetings, frequently taking phone calls, insisting on your agenda prevailing, never having a chance to gossip or exchange small talk (about the Twins, Vikings, weather, families, etc.), often talking about the pressures you and your agency are under, not returning phone calls promptly, and making every request for you to do something a major imposition are all signals that the other members of the group are not valued by you. Such behavior makes it difficult for the other team members to develop a personal bond that can transcend any particular problem the group needs to confront.

9) Defining Whose Need Is Being Met

As was mentioned several times before, both VR and DMH have responsibilities and legislative mandates which run separate courses and overlap, particularly most recently in the provision of employment services to people with severe psychiatric disabilities. Of necessity, there exist demands imposed on professionals by their respective systems which to the extent that these requirements pose demands on the other team members, can cause tensions. For example, the need for each system to define eligibility using different criteria. Or the need to develop both an ICSP and an IWRP.

There is no simple way around these barriers. A strong personal relationship which can be imposed upon can help both staff's needs, particularly where information already on hand in one system is needed by the other. Also, a clear, up front explanation of what the need is why it is important and how the other party can help is essential. If the requesting party defines the need as "paperwork" or "something my supervisor wants", the other professional can be hard pressed to understand why (s)he should be bothered to help.

The same principle holds in trying to get a client to provide information or come in for evaluations. If no good reason is given and no outlining of the positive consequences of this activity are made, the VR or MH professional appears to be little more than a bureaucratic automaton and should not be surprised when others view him/her in the same light.

10) Appropriate vs Inappropriate Clients "Readiness"

First, refer to Marrone's Rule Number 6 on the opening page. Not only is it deleterious to client interests to think of someone as an "inappropriate referral", it is usually infuriating to the person making the referral. If we cannot help someone obtain what they want from us (e.g. an SE job) it is not necessarily the system's "fault", but it certainly is a limitation it has in delivering services. A customer who goes to a store which is out of the product (s)he wants or doesn't like the price, is not labelled an "inappropriate customer". The store management either obtains the product, lowers the price or accepts the fact that it is not interested in that customer's business. If enough customers leave the store, management generally rethinks its policy - not laments how difficult the customers are these days.

An effective team needs to understand differing mandates and priorities but seeks to expand the limits of what it can do by using all the resources at its disposal. Team members must stretch the limits of acceptability and appropriateness to their furthest boundaries if severely psychiatrically disabled people are to gain access to employment. Besides, the humanistic rationale for this approach, there is a technical reason. The capacity to predict vocational success from data available at time of referral is spotty at best. Usually what is clear are the barriers to successful employment. What is unclear is the susceptibility of these barriers to effective rehab interventions. Diagnostic information is not a good predictor of employment functioning.

Because of the flexibility built into the VR and the new DMH Case Management system, there is a human tendency to protect oneself from being overwhelmed and being put on the spot by being quite cautious over who gets "let in" because it is difficult to get extricated once involved. Since the DMH Case Management system is fairly new, no clear track record has emerged in this record.

VR, being the more mature system, has a set of traditions. All too often, the VR system - which has an extremely flexible client-driven service design - gets presented by VR staff as an incredibly rigid, restrictive system. The most important referral questions for a referror to ask are "Does this person want to consider the possibility of work for themselves" and "Is the situation the person is in uncomfortable enough for them that they are willing to go through some effort to change?". There are certainly guidepoints which DMH referral people can use, as outlined in the article on "Serving Psychiatrically Disabled People Within The VR System" by Joe Marrone. However, the crucial questions are those two above. Assessing whether a person meets the VR legal eligibility criteria is the VR staff's job, not the referral agency.

The traditional "tight" description of VR services was brought to mind by a recent workshop I conducted in Connecticut. The room we used was off of a swimming pool area and contained "Rules for Pool Use". Reading this list reminded me of a typical VR informational talk I have heard given many times. The list included 14 rules - all of them began with "No" or "Don't" and I had to read to Number 9 before swimming was mentioned!

An expansive presentation of the possibilities in the VR system of delivering SE services to people with severe and prolonged mental illness would communicate a message of "Come on in, have fun and swim", not "Don't bring glass containers into the pool area".

FUNCTIONAL LIMITATION FACTORS RESULT FROM IMPAIRMENT AND MUST SERIOUSLY LIMIT THE FUNCTIONAL CAPACITIES

1. Physical Mobility
   . Limited personal mobility
   -- includes, but not limited to, ambulation, transportation, accessibility.

2. Dexterity and Coordination
   . Limited dexterity and coordination
   -- includes, but not limited to, basic life skills, independent self-care, ability to write or successfully manipulate objects.

3. Physical Tolerance
   . Limited physical tolerance
   -- includes, but not limited to, endurance, speed, or fatigue.

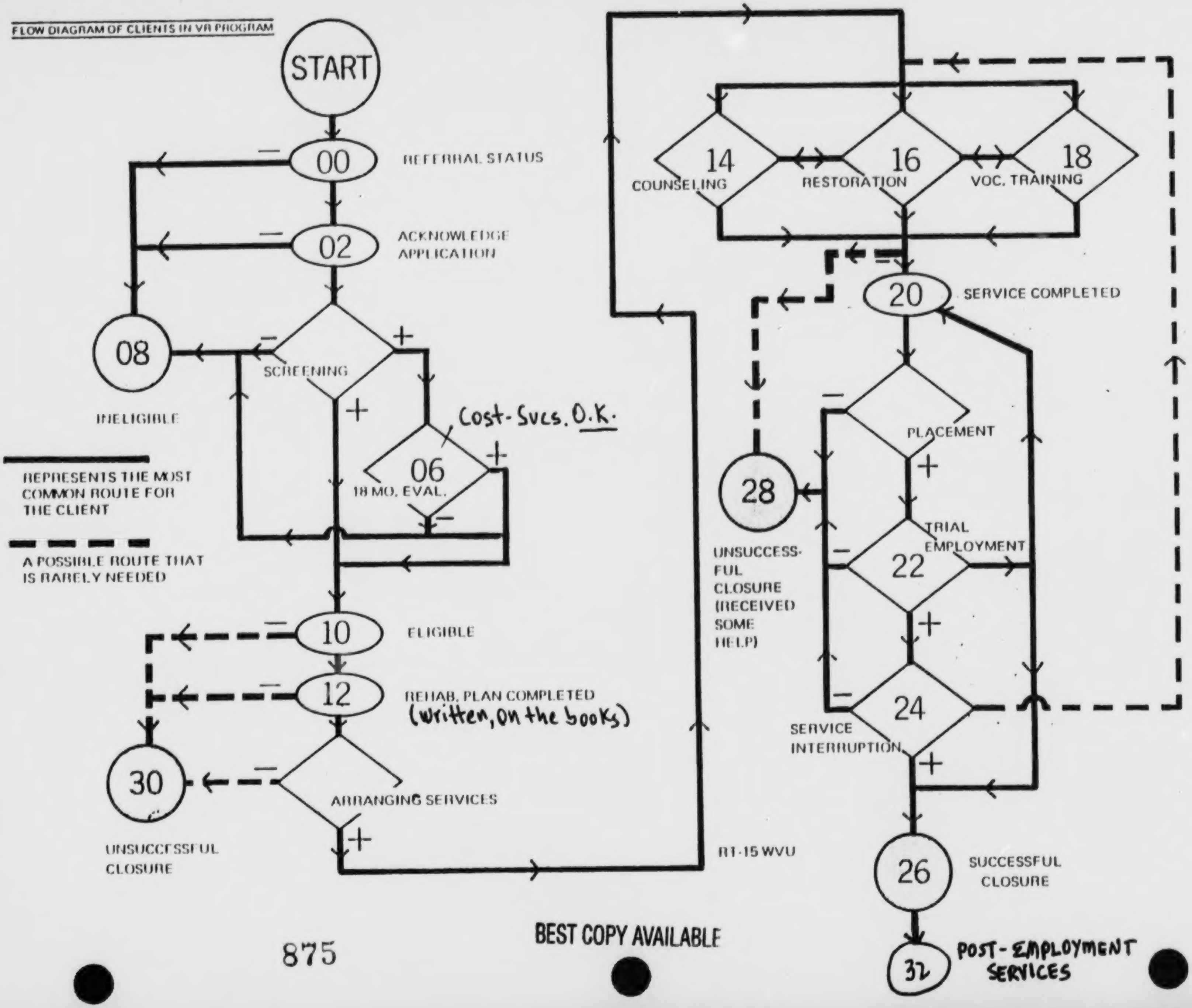
4. Personal Behaviors
   . Inappropriate behaviors
   -- includes, but not limited to, interpersonal relationships, attendance, punctuality, grooming, hygiene, or social responsibility.

5. Capacity to Learn
   . Limited learning capacity
   -- includes, but not limited to, reduced capacity to retain or learn at an acceptable rate through traditional means due to difficulties with visual or auditory processing, cognitive integration, retention or retrieval of information, or reduction of sensory receptivity.

6. Repeat Hospitalizations
   . The severity of the impairment caused repeated hospitalizations.

7. Environmental Interaction
   . Limited ability to perceive or interact with the environment
   -- includes, but not limited to, communication, safety, health.

8. Life Planning
   . Inability to determine the direction of one's own life
   -- includes, but not limited to, limited ability to think through choices to a logical conclusion.

FLOW DIAGRAM OF CLIENTS IN VR PROGRAM
START
00
REFERRAL STATUS
02
ACKNOWLEDGE APPLICATION
SCREENING
08
INELIGIBLE
06
18 MO. EVAL.
Cost-Svcs. O.K.
REPRESENTS THE MOST COMMON ROUTE FOR THE CLIENT
A POSSIBLE ROUTE THAT IS RARELY NEEDED
10
ELIGIBLE
12
REHAB. PLAN COMPLETED
(written, on the books)
ARRANGING SERVICES
30
UNSUCCESSFUL CLOSURE
14
COUNSELING
16
RESTORATION
18
VOC. TRAINING
20
SERVICE COMPLETED
PLACEMENT
28
UNSUCCESSFUL CLOSURE (RECEIVED SOME HELP)
TRIAL EMPLOYMENT
22
24
SERVICE INTERRUPTION
26
SUCCESSFUL CLOSURE
32
POST-EMPLOYMENT SERVICES
RT-15 WVU
+
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3005.01 Purpose and Legal Authority

Statistical reporting under the State-Federal Program of Vocational Rehabilitation is sponsored by the Rehabilitation Services Administration (RSA) and conducted under the auspices of the National Center for Social Statistics (NCSS) acting as the collecting and processing agency for RSA-sponsored reports. This section contains copies of the required statistical reports and instructions for preparing them.

Section 101(a)(10) of the Rehabilitation Act of 1973 and Section 401.21 of the Proposed Regulations dated May 28, 1974 which implement the Act, relate to the submittal of reports.

3005.02 Caseload Statuses

There are 15 status classifications under the caseload status coding structure coded in even numbers beginning with 00 and ending with 30 (excluded is code 04). Reporting on all statistical forms is based on one or more of the caseload statuses.

Status 00. REFERRAL. This status represents entrance into the vocational rehabilitation process. A referral is defined as any individual who has applied to or been referred to the vocational rehabilitation agency by letter, by telephone, by direct contact, or by any other means; and for whom the following minimum information has been furnished: (1) name and address, (2) disability, (3) age and sex, (4) date of referral, and (5) source of referral.

It should be noted that it is not intended to include in the definition of "referrals" those individuals included in long lists of persons who are "screened out" by criteria established in a cooperative agreement between the vocational rehabilitation agency and another agency. However, all those cases not screened out by the established criteria should be recorded and reported, not just the cases which appear to have good vocational rehabilitation potential after counselor investigation.

All cases must be recorded and reported as referrals for Form SRS-RSA-101 and Form SRS-RSA-300 purposes as soon as the above basic, minimum information is available. Recognition of this basic principle by all counselors and all State vocational rehabilitation agencies is essential. Referrals should be recorded on these forms even though the counselor may close out the referral almost immediately as not being eligible for services.

Status 02. APPLICANT. As soon as the referred individual (Status 00) signs a document requesting vocational rehabilitation services, he is placed into Status 02 and is designated as an applicant. Generally, the document will be an agency application form, but a letter signed by an individual who provides the minimum basic referral information and requests service should also be considered as a basis for placing the individual in Status 02. This is important, since the applicant must be notified in writing if his request for VR services has been denied, and the only certain basis for determining that the individual has knowledge of having been referred is by the existence of a document signed by the individual.

While the individual is in Status 02, sufficient information is developed to make a determination of eligibility (Status 10) or ineligibility (Status 08) for vocational rehabilitation services, or a decision is made to put the individual into extended evaluation (Status 06) prior to making such a determination.

Status 06. EXTENDED EVALUATION. An applicant should be placed in this status when the counselor has certified the applicant for extended evaluation. Individuals placed in this status may not remain in the status longer than eighteen consecutive months from the date of certification but may be moved from this status to either Status 10 or 08 at any time prior to the expiration of the 18-month period if it is determined that, either (a) there is a reasonable expectation that the individual can benefit in terms of employability (Status 10), or (b) there is no reasonable likelihood that he can benefit in terms of employability (Status 08). No time allowances can be made for interruptions during this period regardless of the nature of, or reason for, the interruptions.

Prior to or simultaneously with acceptance of an individual for services for purposes of determination of rehabilitation potential (extended evaluation), there will be a certification of: (1) the presence of a physical or mental disability, (2) the existence of a substantial handicap to employment, and (3) the inability to make a determination that vocational rehabilitation services may benefit the individual in terms of employability. An individualized written rehabilitation program is required concurrently with or reasonably soon after execution of the certificate of eligibility for extended evaluation services.

Status 08. CLOSED FROM REFERRAL, APPLICANT, OR EXTENDED EVALUATION STATUSES. This status has been provided to furnish a means for identifying all persons not accepted for vocational rehabilitation services, whether closed from referral status (00), applicant status (02), or extended evaluation (06). All persons processed through referral, applicant, and/or extended evaluation, and not accepted into the active caseload for vocational rehabilitation services, will be closed in this status. A certificate of ineligibility is required for a closure in Status 08, except when the client becomes unavailable for services. A copy of the Form SRS-RSA-300, properly completed, dated, and signed is sufficient certification of ineligibility for these cases, provided case documentation includes specific detailed reasons for the closure action. See page 75 for additional instructions concerning closure of cases.

ACTIVE CASELOAD STATUSES

An individual who has been certified as meeting the three basic eligibility requirements is accepted for vocational rehabilitation services, designated as an active case, and placed in Status 10. Eligibility for vocational rehabilitation services is based upon: (1) the presence of a physical or mental disability; (2) the existence of a substantial handicap to employment; and (3) a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability.

After an individual has been accepted and his case placed in the active caseload, the case study is completed, an individualized written rehabilitation program is developed, and the appropriate services are provided, including follow-up prior to case closure to insure the suitability of employment.

The following statuses are designed to provide counselors, district supervisors, and State agency management personnel with a uniform method for recording individual case progress and caseload management information. It may be noted that there are no national reporting requirements for applying these statuses to cases in extended evaluation. However, any large-volume agency desiring to establish case progress identification for their evaluation cases can easily do so by prefixing the following statuses with a "6" to signify status changes during extended evaluation.

Status 10. INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM DEVELOPMENT. While a client is in this status, the case study and diagnosis is completed to provide a basis for the formulation of the individualized written rehabilitation program. A comprehensive case study is basic to determining the nature and scope of services to be provided in order to accomplish the vocational rehabilitation objective of the individual. The counselor and client formulate and plan the rehabilitation services necessary to the solution of the client's problems, and those services are clearly outlined to him. The individual remains in this status until his rehabilitation program is written and approved.

Status 12. INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM COMPLETED. A case is placed in this status when the individualized program has been written and approved. The case remains in this status until at least one arrangement has been made to supply a necessary service and the service has been actually initiated. In those instances where the program as written and approved provides for counseling, guidance, and placement only, the client may be moved immediately after program approval into Status 14 since counseling is a continuing process.

THE IN-SERVICE STATUSES (Statuses 14, 16, and 18). These service statuses are provided for case progress designations to indicate the kind or kinds of services given to the client to prepare him for employment.

In those instances where a client receives restoration and training services simultaneously, the client should be identified by the service which is running for the longer period of time. In those instances where both services run concurrently for the same time period, the counselor must use his professional judgment in assigning the case to the status which is most important to that particular case.

Status 14. COUNSELING AND GUIDANCE ONLY. It is intended that this status be used only for those cases having an approved program which outlines counseling, guidance, and placement as the only services required to prepare the client for employment. It is not to be used to reflect the counseling and guidance which take place during the course of program development or provided by the counselor during the progress of training, or physical or mental restoration. However, within the context of the meaning and intent above, in those instances where there has been a breakdown in the case progress after other services have been provided, and it has been determined by the counselor that substantial counseling and guidance is essential to the successful placement and rehabilitation of the individual, the client may be entered in this status, provided that a program amendment has been written and approved after consultation with the client and that this is the only additional service required to prepare the client for employment.

Status 16. PHYSICAL AND MENTAL RESTORATION. A client is placed in this status if he is receiving any physical or mental restoration services such as medical, surgical, psychiatric or therapeutic treatment, or is being fitted with an appliance. A case remains in this status until physical and mental restoration services are completed or terminated.

Status 18. TRAINING. A client is placed in this status if he is actually receiving academic, business, vocational or personal and vocational adjustment training from any source such as a public or private school, a commercial or industrial establishment, a rehabilitation or other facility, by an individual

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teacher or instructor, or by correspondence. Clients remain in this status until the training is either completed or terminated.

Status 20. READY FOR EMPLOYMENT. A client is placed in this status when he has completed preparation for employment (counseling, guidance, treatment, fitting of an appliance, training, etc.) and is ready to accept a job but has not yet been placed, or has been placed but has not yet begun employment. For example, "June graduates" with teaching contracts, who will not begin employment until September, should be placed in this status for Federal reporting purposes.

Status 22. IN EMPLOYMENT. A client is placed in this status when he has been prepared for, been placed in, and begun employment. He must be observed in this employment for a minimum of 60 days prior to being -60 days closed rehabilitated (Status 26) to insure adequacy of employment in accordance with the needs and limitations of the individual. Homemakers and unpaid family workers should be included in this status while they meet the observation criteria.

Status 24. SERVICE INTERRUPTED. A client is recorded in this status if services are interrupted while he is in one of the Statuses 14, 16, 18, 20, or 22. Such cases are then held in this status until the client returns to one of the aforementioned statuses or until the case is closed.

ACTIVE CASELOAD CLOSURE STATUSES

A client remains in the active caseload until he has completed his individualized written rehabilitation program or until it has been terminated. Cases closed from the active caseload are classified in one of the three following categories.

Status 26. CLOSED REHABILITATED. Cases closed as rehabilitated must as a minimum (1) have been declared eligible, (2) have received appropriate diagnostic and related services, (3) have had a program for vocational rehabilitation services formulated, (4) have completed the program insofar as possible, (5) have been provided counseling as an essential rehabilitation service, and

(6) have been determined to be suitably employed for a minimum of 60 days. See page 75 for additional instructions concerning closure of cases.

Status 28. CLOSED OTHER REASONS AFTER INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM INITIATED. Cases closed in this category must have met the criteria (1), (2), and (3) above, and at least one of the services provided for by the program must have been initiated, but for some reason one or more of criteria (4), (5), and (6) above were not met (closures from Statuses 14 through 24). Included here are cases which are transferred to another State rehabilitation agency, either within the State, or in some other State. Also included here are those cases for which a rehabilitation program for counseling and guidance only was written, approved, and initiated. See page 75 for additional instructions concerning closure of cases.

Status 30. CLOSED OTHER REASONS BEFORE INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM INITIATED. Cases closed in this category are those cases which, although accepted for rehabilitation services, did not progress to the point that rehabilitation services were actually initiated under a rehabilitation plan (closures from Status 10 or 12). Included here are cases which are transferred to another State rehabilitation agency, either within the State, or in some other State. See page 75 for additional instructions concerning closure of cases.

Status 32. POST-EMPLOYMENT SVCS - Client is eligible for OVR services for up to one year after being closed in Status 26.

SAMPLE VR REFERRAL LETTER

December 1, 199

Robert Shields, Rehabilitation Counselor
Office of Vocational Rehabilitation
State Office Building
300 Liberty Avenue
Pittsburgh, PA 15222

Dear Mr. Shields:

This letter is to verify that (WPIC# , SSN), carries the DSM-III-R diagnosis of Bipolar Disorder, Manic in partial remission (296.45), which was originally made in 1982. Treatment for Mrs. includes bi-weekly individual psychotherapy sessions with Caroline Haak, LSW, of the Comprehensive Care Program (CCP), Western Psychiatric Institute and Clinic (WPIC), and pharmacological treatment with Lithium 900mg daily, Trilafon 10 mgs every day, and Cogentin 4mg every evening under the direction of Dr. James Jacobson. Mrs. will also be seen for vocational rehabilitation services by Maribel Baez, B.A. and Michelle Geckle, M.Ed., CRC, in the Psychiatric Rehabilitation and Assessment Services (PRAS) Clinic of WPIC.

Mrs. is a woman of 53 years who worked as a secretary for 25 years. She lost her job in 1985 and since that date has been working in part-time and temporary secretarial positions. Since 1992, Mrs has had serious difficulties finding a job as a secretary as a result of her lack of skills with computers. She completed a developmental career job-seeking skills training program via in January 199 (i.e. interviewing skills, resume, job seeking) and has continued to actively seek employment but without response to date.

Mrs. is doing well with her treatment and is highly motivated to improve herself educationally and vocationally. She is most interested in obtaining education/skill training in the computer field, i.e. word processing, data base management, which in combination with her 25 years of secretarial experience, should qualify her for competitive employment.

Functional limitations secondary to Mrs. 's mental illness include, but are not limited to, episodic distractibility, irritability, rapid speech, mood swings, insomnia, cognitive confusion and increased activity. Mrs. has not had a manic episode since May 1992 and her symptoms are well controlled with medication and therapy. She is supported by SSDI and resides in the s housing project.

Mrs. applied (12/9 for the Information Sciences Program at Bidwell Training Center, Inc. and met all entry requirements except for Reading Comprehension level. She hopes to improve this skill via classes at Bidwell and be accepted for the

February 19 training program.

Any assistance which you may provide Mrs will be greatly appreciated. She could particularly benefit from assistance with transportation costs associated with school. Please do not hesitate to contact me if I may be of any further assistance to you.

Sincerely,

Lynda J. Katz, Ph.D.
PS# 002822-L

OVR - 104
Rev. 9/86

Commonwealth of Pennsylvania
Department of Labor and Industry
OFFICE OF VOCATIONAL REHABILITATION

OVR COUNSELOR ____________ District Office

Social Security No. ____________

Case No. ____________

W/E S.S. No. ____________

INITIAL INTERVIEW

Name--Last ____________ First ____________ Initial ____________

Address ____________ City ____________ Zip ____________

County ____________ Township ____________ Phone ____________

Referral Source ____________ Birthdate ____________ Sex ____________

Disability ____________

Client's Explanation of Wants and Needs from OVR ____________

DISABILITY AND LIMITATIONS

Client's statement of disability(ies) and onset date (year) ____________

Client's statement of how disability limits him/her and interferes with ability to work ____________

MEDICAL HISTORY

Family Doctor ____________ Address ____________

Date Last Seen ____________ Reason ____________

Specialist Name ____________ Address ____________

Date Last Seen ____________ Reason ____________

Specialist Name ____________ Address ____________

Date Last Seen ____________ Reason ____________

Phys/Mental Clinic ____________ Address ____________

Date Last Seen ____________ Reason ____________

Future Appointments ____________

Medications and Dosages ____________

Height ____________ Weight ____________

Admissions to Medical Facilities for Vocationally Disabling Conditions

Name ____________ Address ____________

Date ____________ Reason ____________

Name ____________ Address ____________

Date ____________ Reason ____________

Hospital and Surgical Insurance

Insurance Carrier ____________

Address ____________ Litigation Pending? ☐ Yes ☐ No

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Disability Compensation or Pension Data

Insurance Carrier ____________________ Monthly Amount __________

Address ____________________ Date Began __________

Policy or Claim Number ____________________ Expiration Date __________

Private Rehabilitation Agency ____________________

Address ____________________ Counselor __________

VOCATIONAL BACKGROUND (starting with most recent employer) **SOC Code - Most Recent Job** __________

EMPLOYER	TITLE	MONTH/YEAR FROM/TO	REASON FOR LEAVING	PT/FT	WAGE

Duties ____________________ Supervisor __________

Duties ____________________ Supervisor __________

Duties ____________________ Supervisor __________

Duties ____________________ Supervisor __________

Duties ____________________ Supervisor __________

Military Service and Dates ____________________ Type Discharge __________

Benefits ____________________

Job Duties ____________________

Other Skills / Assets / Equipment Operated ____________________

Car ______ Driver's License and Class __________ Public or Other Transportation Available? ______ Accessible? ______

Vocational Choices ____________________

Leisure Activities ____________________

EDUCATION

High School ____________________ Course __________ Graduated-Year ______

Years Attended ______ Years Completed ______ Reason for Leaving __________

Other Education or Training ____________________

Highest Grade Completed ______ GED ______

PERSONAL AND FAMILY INFORMATION

NAME	AGE	RELATIONSHIP	EMPLOYER	COMMENTS

Other Support ____________________

FINANCIAL

Client Source(s) of Income and Amount ______

Other Income and Amount ______

AGENCY INVOLVEMENT

Agency ______ Caseworker ______

Services Received ______

Agency ______ Caseworker ______

Services Received ______

COMPLETE AS APPLICABLE

HISPANIC ORIGIN

- ☐ Yes
- ☐ No

RACE

- ☐ 1 White
- ☐ 2 Black
- ☐ 3 American Indian, Alaskan Native
- ☐ 4 Asian or Pacific Islander

PREVIOUS CLOSURE

- ☐ No
- ☐ Yes ______ Month/Year
- ☐ Rehab
- ☐ Non-Rehab

MARITAL STATUS

(Voluntary, used for data collection, not used for eligibility determination)

- ☐ 1 Married
- ☐ 2 Widowed
- ☐ 3 Divorced
- ☐ 4 Separated
- ☐ 5 Never Married
- ☐ 6 Chose not to respond

TYPE OF INSTITUTION

- ☐ 00 Not in Institution at Application
- ☐ 01 Public Mental Hospital
- ☐ 02 Private Mental Hospital
- ☐ 03 Psychiatric Inpatient--General Hospital
- ☐ 04 Community MH Center--Inpatient
- ☐ 05 Public Institution for MR
- ☐ 06 Private Institution for MR
- ☐ 07 Alcoholism Treatment Center
- ☐ 08 Drug Abuse Treatment Center
- ☐ 09 School and Other Institution for Blind
- ☐ 10 School and Other Institution for Deaf
- ☐ 11 General Hospital
- ☐ 12 Hospital or Specialized Facility for Chronic Illness
- ☐ 13 Institution for Aged
- ☐ 14 Halfway House
- ☐ 15 Correctional Institution--Adult
- ☐ 16 Correctional Institution--Juvenile
- ☐ 17 Other Institutions and Special Living Arrangements

PRIMARY SOURCE OF SUPPORT

- ☐ 00 Current Earnings, Interest, Dividends, Rent
- ☐ 01 Family and Friends
- ☐ 02 Private Relief Agency
- ☐ 03 Public Assistance at Least Partly with Federal Funds (i.e., SSI & AFDC)
- ☐ 04 Public Assistance without Federal Funds (GA only)
- ☐ 05 Public Institution--Tax Supported
- ☐ 16 Federal Workers' Compensation
- ☐ 26 Private Workers' Compensation
- ☐ 36 Self-Insured Workers' Compensation
- ☐ 46 State Workers' Insurance Fund
- ☐ 07 Social Security Disability Benefits
- ☐ 08 All Other Public Sources
- ☐ 09 Annuity or Other Non-Disability Insurance Benefits (Private Insurance)
- ☐ 10 All Other Sources of Support

WORK STATUS

- ☐ 1 Competitive Labor Market
- ☐ 2 Sheltered Workshop
- ☐ 3 Self-Employed (except BEP)
- ☐ 4 State Agency Managed Business Enterprise (BEP)
- ☐ 5 Homemaker
- ☐ 6 Unpaid Family Worker
- ☐ 7 Not Working: Student
- ☐ 8 Not Working: Other
- ☐ 9 Not Working: Trainee or Worker in Non-Competitive Employment

WEEKLY EARNINGS $______

HOURS PER WEEK ______

PUBLIC SUPPORT

☐ SSI ☐ GA ☐ AFDC ☐ SSDI

- ☐ Aged
- ☐ Blind
- ☐ Disabled

Claim Type ______

PA Monthly Amount $______

Claim Type ______

- ☐ Veterans Disability
- ☐ Other Disability
- ☐ All Other Support Payments

Records Requested from ______

Forms Given: ☐ Handbook ☐ OVR-701 ☐ OVR-1 ☐ CAP

Vocational Rehabilitation has been explained to me and I am requesting services.

Client Signature .... Date ....

Parent/Guardian Signature ....

Counselor Signature .... Date ....

BEST COPY AVAILABLE

Counselor's Assessment of Client's Wants and Needs

ADDITIONAL COMMENTS

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Rev. 10/93

Commonwealth of Pennsylvania
Department of Labor and Industry
OFFICE OF VOCATIONAL REHABILITATION

CERTIFICATE OF ELIGIBILITY

Sec 102(a)(1)

Client ______________________________ S. S. No. ____________________

I. INDIVIDUAL WITH DISABILITY Sec 7 (8) (A)

The individual has a disability, is a recipient of SSDI or SSI and is considered to have a severe physical or mental impairment which constitutes or results in a substantial impediment to employment.

____Yes (Do not complete I.B.)

____No (Complete I.A., I.B., and I.C.)

A. IMPAIRMENT(S)

	Code	Diagnosis
Primary		
Secondary		

B. SUBSTANTIAL IMPEDIMENT TO EMPLOYMENT

Discuss how the functional limitations create a substantial impediment to employment.
Relate employment impediments to specific job tasks.

C. IT IS PRESUMED THE INDIVIDUAL CAN BENEFIT IN TERMS OF EMPLOYMENT OUTCOME
OR

___ Due to the nature of and severity of the impairment, there is an inability to determine that vocational rehabilitation services can benefit the individual in terms of employment outcome unless there is an Extended Evaluation.

II. NEED FOR VOCATIONAL REHABILITATION SERVICES

Identify service(s) needed to prepare for, enter, engage in, or retain gainful employment.

____ Assessment
____ Counseling, Guidance, Work Related Placement
____ Training
____ Physical and Mental Restoration
____ Maintenance
____ Interpreter Services
____ Recruitment and Training Services
____ Rehabilitation Teaching Services and Orientation and Mobility Services
____ Occupational Licenses, Tools, Equipment, and Initial Stocks and Supplies
____ Transportation
____ Telecommunications
____ Rehabilitation Technology
____ Transition
____ On-The-Job/Personal Assistance
____ Supported Employment
____ Referral to Other Agencies
____ Other (name the service)____

________________________ Counselor
________________________ Supervisor (applies to VRC I only)
________________________ Mo/Day/Year

SEVERITY OF DISABILITY

______ Most severely disabled
______ Severely disabled
______ Not severely disabled

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COMMONWEALTH OF PENNSYLVANIA – DEPARTMENT OF LABOR AND INDUSTRY
OFFICE OF VOCATIONAL REHABILITATION

INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM

The Individualized Written Rehabilitation Program (IWRP) is developed jointly by you and your counselor. The IWRP is not a legal contract. This program may be subject to approval by administrative staff and the availability of funds.

☐ Original ☐ Amendment ☐ Change of Service ☐ Change of Goal ☐ Post-Employment

NAME STATUS DATE

☐ You are eligible for vocational rehabilitation services.

☐ You will begin a period of EXTENDED EVALUATION to determine if you can benefit from vocational rehabilitation services in terms of employment outcome

VOCATIONAL GOAL S.O.C. CODE

HOW THE GOAL WILL BE ACHIEVED:

OBJECTIVE

SERVICE(S)/PROVIDER(S)	SB	RESPONSIBLE PARTY	BEGINNING DATE	PROJECTED END DATE

PROGRESS EVALUATION METHOD & SCHEDULE

YOUR RESPONSIBILITIES

POST EMPLOYMENT ASSESSMENT

OBJECTIVE

SERVICE(S)/PROVIDER(S)	SB	RESPONSIBLE PARTY	BEGINNING DATE	PROJECTED END DATE

PROGRESS EVALUATION METHOD & SCHEDULE

YOUR RESPONSIBILITIES

POST EMPLOYMENT ASSESSMENT

OBJECTIVE ______________________________

SERVICE(S)/PROVIDER(S)	SB	RESPONSIBLE PARTY	BEGINNING DATE	PROJECTED END DATE

PROGRESS EVALUATION METHOD & SCHEDULE ______________________________

YOUR RESPONSIBILITIES ______________________________

POST EMPLOYMENT ASSESSMENT ______________________________

YOUR STATEMENT, AND ANY REPRESENTATIVE'S STATEMENT, DESCRIBING HOW YOU WERE INFORMED ABOUT AND INVOLVED IN CHOOSING AMONG ALTERNATIVE GOALS, OBJECTIVES, SERVICES, SERVICE PROVIDERS, AND SERVICE METHODS

UNDERSTANDINGS

ELIGIBILITY CRITERIA

To be eligible for vocational rehabilitation services you must have an impairment which results in a substantial impediment to employment; you must be able to benefit in terms of employment outcome and you must require services to prepare for, enter, engage in or retain gainful employment.

YOUR RESPONSIBILITIES

It is your responsibility to cooperate in carrying out the rehabilitation program and to make reasonable efforts to attain your rehabilitation objectives and goals. Continuation of services is dependent upon your meeting your responsibilities.

YOUR RIGHTS AND REMEDIES

It is your right to be fully consulted regarding any amendment or change to your rehabilitation program. You may discuss a problem or grievance with your rehabilitation counselor at any time upon scheduling an appointment. You may file a request for an impartial hearing before an Impartial Hearing Officer. The request must be mailed to the Director of Program Operations, OVR, Room 1310, Labor and Industry Building, 7th and Forster Streets, Harrisburg, PA 17120-9975. The request shall state the reason for the appeal, and the action, services, or relief you want; and be sent within thirty (30) days of the decision with which you are dissatisfied.

If you are not satisfied with rehabilitation services or the denial of services, you may contact the Client Assistance Program (CAP) in Philadelphia at 215/557-7112 (voice or TDD), in Pittsburgh at 412/363-7223 (voice or TDD), or toll free 1/800/742-8877 (voice or TDD). CAP staff can give advice and provide clarification or assistance with the services provided by OVR or other agencies. CAP staff can work with you and OVR staff to give you information and to resolve problems.

If your status is changed from eligible to ineligible, you will be given the opportunity for full consultation in such a decision. Ineligibility decisions will be based upon factors which are recorded in the official case record, and the decision will be certified by the appropriate OVR staff member. If ineligible because you cannot benefit from OVR services, you will be given the opportunity to participate in an annual review of that decision.

ANNUAL REVIEW OF PROGRAM

At least once each twelve months there will be a review of your rehabilitation program at which time you will have the opportunity to jointly develop its terms with your counselor.

CONFIDENTIALITY

All information acquired as part of the rehabilitation process shall remain the property of OVR. It is strictly confidential. Information shall be used only for purposes directly related to the administration of your rehabilitation program. This information will not be shared with anyone except Pennsylvania OVR staff or other agencies with whom the agency has a written cooperative agreement without your informed written consent or that of your representative, unless required by law.

I have participated in the development of this rehabilitation program and I understand and accept its provisions.

Client	Date	Parent Advocate	Date
Counselor	Date	Supervisor (VRC I only)	Date
		Copy given sent	Date

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OFFICE OF VOCATIONAL REHABILITATION

REQUEST FOR FINANCIAL AID INFORMATION

Academic Year________ Terms: ☐ Fall ☐ Winter ☐ Spring ☐ Summer

District Office ____________________ Counselor ______________________________

Name ____

Social Security Number ______________________ Age_____

Address ____

Institution ____

Student Enrollment Status: ☐ Full-Time ☐ Part-Time

Client Release Statement: I hereby request the release to the Office of Vocational Rehabilitation of all information necessary to complete the items listed on this form. This information will be used solely for the purpose of determining the amount of financial aid that OVR can provide and will remain confidential unless expressly released by me in writing.

Date ______________________ *Student Signature* ______________________________

Parent Signature ______________________________

(only necessary if student is under age 18)

TO BE COMPLETED BY POSTSECONDARY INSTITUTION

Housing status:	1. Cost of attendance*	$________	4. PHEAA grant	$________
[ ] Commuter	2. Family contribution**	$________	5. Other grants & scholarships	$________
[ ] Dormitory	3. Pell grant	$________	6. PHEAA max. gift aid amount***	$________
[ ] Off-campus			Is student in default status? [ ] Yes [ ] No	

Time frame to which this information is applicable:

From____________ ______________________ To______________________________
Month/Day/Year *Month/Day/Year*

Student Enrollment Status (form should not be delayed if enrollment status is not available) ☐ Full-Time ☐ Part-Time

Date __________________ *Financial Aid Administrator Signature* ______________________________

* The education expense budget should include tuition, fees, books, supplies, room, board and personal costs (clothing, laundry, recreation, transportation, etc) but not include additional expenses incurred because of the student's disability (e.g. attendant care, interpreter, notetaker).

** The amount of the expected family contribution according to Congressional Methodology.

*** To be furnished even if a student is not PHEAA eligible.

Upon completion form is to be returned to:

OFFICE OF VOCATIONAL REHABILITATION

Attn: ______________________________

____

____

To be completed by OVR

OVR Allowable Grant Lessor of

a) OVR Unmet Need x 80% ________
(+ 1-2-3-4) x .80

or

b) OVR Gift Aid Max. ________
(+ 6-3-4-5)

SE1.

MODELS OF
VOCATIONAL PROGRAMMING

WORK UNITS

VOLUNTEER WORK EXPERIENCES

TRANSITIONAL EMPLOYMENT

WORK CREWS
(INCLUDING SUB-CONTRACT IN INDUSTRY)

SE2.

CLIENT-RUN BUSINESSES
OR
AFFIRMATIVE INDUSTRIES

SUPPORTED EMPLOYMENT

LIAISON WITH VR

JOB PLACEMENT

SE3.

VOCATIONAL PROGRAMING MODELS

WORK UNITS

BASICS	TYPES
- CLUB SUSTAINING WORK (SELF-BENEFIT) NOT VOLUNTEER WORK OR SKILLS TRAINING , OR WORK ADJUSTMENT	- CLERICAL - HOUSEKEEPING - FOOD SERVICE - FISCAL - PUBLIC RELATIONS, TOURS
- WORK UNIT ASSIGNMENT NOT ESSENTIAL	
- NOT BEST PLACE FOR SKILLS TRAINING	

SE4.

VOCATIONAL PROGRAMMING MODELS

VOLUNTEER WORK EXPERIENCES

PRO	CON
- HIGH LEVEL JOBS	- FINANCES
- LOW ENERGY, LESS TIME	- LITTLE FORMAL STRUCTURE
- NOT A "PROGRAM"	- CLIENT COMMUNICATION
- NURTURANCE	- D.O.L. REGULATIONS

SE5.

VOCATIONAL PROGRAMMING MODELS

SUPPORTED EMPLOYMENT

1) COMPETITIVE WORK

- AVERAGE 20 HOURS WEEK
- PAID, BUT NOT NECESSARILY MINIMUM WAGE

2) INTEGRATED SETTING

- MAJORITY IS NOT HANDICAPPED
  NO HANDICAPPED WORK GROUP

- MAJORITY IS NOT HANDICAPPED
  NO MORE THAN 8 IN GROUP

- SEGREGATED (1-8 PEOPLE)
  REGULAR CONTACT WITH NON-HANDICAPPED
  PEOPLE

3) ON-GOING SUPPORT

- AT LEAST 2 X MONTH

SE6.

COMPONENTS OF SUPPORTED EMPLOYMENT FOR PERSONS WITH PROLONGED MENTAL ILLNESS

- JOB PLACEMENT
- JOB SITE TRAINING AND ADVOCACY
- ON-GOING MONITORING
- FOLLOW-UP AND RETENTION
- INTEGRATED SETTINGS
    - NO MORE THAN 8 PEOPLE

SE7.

- TRAINEE INVOLVEMENT IN WORK SLOT CHOICE
- RANGE OF JOBS
- "PASSING"
- COMMUNITY ADVOCACY AND CASE MANAGEMENT
- STAY OUT OF THE "FAST-TRACK"
- INVOLVEMENT PRE-POST

SE8.

VOCATIONAL PROGRAMMING MODELS

TRADITIONAL TEP

1. TIME LIMITED
2. PROGRAM "OWNS" JOB
3. ENTRY LEVEL-HIGH TURNOVER

PRO	CON
• GRADUATION	• TRANSITION DIFFICULT
• "LIGHT AT THE END OF THE TUNNEL"	• NEED FOR HIGH VOLUME OF JOBS
• EMPLOYERS MORE WILLING TO TAKE RISKS	• TRANSFERABILITY OF SKILLS
• URBAN	• RURAL
• SERVICE ORIENTED ECONOMY	• INDUSTRIAL BASED ECONOMY
• QUICK TRAINING	• BOREDOM
• VOLUME	

TYPES

- FOOD SERVICE
- HOUSEKEEPING

SE9.

COMPONENTS OF TRANSITIONAL EMPLOYMENT PROGRAM

1. INVOLVEMENT WITH THE PROVIDER FOR OTHER THAN JUST TEP.
2. JOB DEVELOPMENT AND ANALYSIS BY AGENCY.
3. ON THE JOB TRAINING BY AGENCY.
4. ON THE JOB SUPPORT BY AGENCY.
5. EARNING REAL WAGES.

SE10.

6. AGENCY TAKES RESPONSIBILITY FOR THE TRANSITION TO INDEPENDENT COMPETITIVE EMPLOYMENT.
7. PEER GROUP SUPPORT.
8. AGENCY COOPERATION/COLLABORATION WITH OTHER SERVICE PROVIDERS.
9. PRE-PLACEMENT RELATIONSHIP BUILDING.

SE11.

VOCATIONAL PROGRAMMING MODELS

WORK CREWS

PRO	CON
- GROUP SUPPORT	- SEGREGATION
- "HIDE" LOW FUNCTIONING	- LACK OF STEADY WORK
- RURAL	- OFTEN POOR EARNINGS
- FLEXIBLE FOR JOBS	- DIFFICULTY WITH TRANSITION
- INDUSTRIALLY BASED ECONOMY	

TYPES

- CATERING
- CLEANING
- SUB-CONTRACT IN INDUSTRY
- AGRICULTURAL LABOR
- HORTICULTURAL

SE12.

CLIENT EMPLOYING BUSINESS

SE13.

VOCATIONAL PROGRAMMING MODELS
VR LIAISON

A) PRO - SMALL PROGRAM, FEW STAFF

CON - CONTINUITY OF CARE

B) TO UNDERSTAND VR

- INDIVIDUAL PROGRAM OF SERVICES
- ELIGIBILITY = VOCATIONAL REHABILITATION COUNSELOR
- ALL SERVICES PART OF A VOCATIONAL PLAN

SE14.

C) HOW TO LINK WITH VR

- MARKET
    - REHABILITATION PRINCIPLES
    - WORK ADJUSTMENT
- IDENTIFY VR OUTCOMES
    - REHABILITATION'S ("26"s)
    - INCREASE REFERRALS
    - INCREASE REHABILITATION RATE
    - REDUCE FAILURES ("08"s)
- ENGAGE VR COUNSELOR
    - (MORE FREQUENT VS MORE TIME)
- LINK WITH PERSON, NOT SYSTEM
- FUND VIA
    - DAYS WORKED
    - HOURS OF SUPPORT
    - EXTRA STAFF TO DO ASSESSMENT AND RELATIONSHIP BUILDING

SE15.

VR REFERRAL ISSUES

CLIENT CHARACTERISTICS: POSITIVE INDICATORS

1) RECENT AND/OR CONSISTENT WORK HISTORY
2) CLIENT CAN EXPRESS VALUE OF WORK
3) PREDICTABLE COURSE OF ILLNESS
4) CLIENT COOPERATION WITH TREATMENT
5) PARTICIPATION IN SCHEDULED STRUCTURED ACTIVITY
6) GOOD PHYSICAL AND/OR VERBAL IMPRESSION
7) CLIENT OPEN TO VR INPUT
8) "SIGNIFICANT OTHERS" SUPPORT VR INVOLVEMENT.

SE16.

VR REFERRAL ISSUES

CLIENT CHARACTERISTICS: "RED FLAGS"

1) NO DISCHARGE PLAN BEYOND VR REFERRAL
2) NO NECESSARY TREATMENT AVAILABLE
3) NO "STABLE" LIVING SITUATION
4) NO STEADY SOURCE OF INCOME
5) CONTINGENCIES INTERFERE WITH VR PLANNING
6) PROGNOSIS FOR ERRATIC, LONG TERM HOSPITALIZATION
7) "SIGNIFICANT OTHERS" INVESTED IN STATUS QUO
8) CLIENT HAS STRONG INTEREST IN "UNREALISTIC" VOCATIONAL GOAL

SE17.

VR REFERRAL ISSUES

CLIENT CHARACTERISTICS: NEGATIVE INDICATORS

1) CLIENT ASSAULTIVE TO COUNSELOR
2) CLIENT CAN'T COMMUNICATE CONSISTENTLY DUE TO SYMPTOMATOLOGY
3) CLIENT WON'T LEAVE HOME TO SEE COUNSELOR, EVEN WITH ADVOCATE
4) CLIENT WON'T GO FOR EVALUATIONS
5) 2 "NOSHOWS" WITHOUT A "GOOD" EXCUSE
6) CARRIES A WEAPON

SE18.

VR REFERRAL ISSUES

SYSTEM-ORGANIZATIONAL: POSITIVE INDICATORS

1) MH FACILITY PROVIDING "QUALITY" SUPPORT
2) REGULAR STRUCTURED CONTACT BETWEEN VR & MH
3) MH PROGRAM WILLING TO SET UP STRUCTURED PROGRAM
4) VR COUNSELOR HAS KNOWLEDGE OF MH
5) VR COUNSELOR HAS EDUCATED MH RE:VR
6) MH HAS REHABILITATION COUNSELOR
7) MH STAFF CAN DO FUNCTIONAL EVALUATIONS
8) INTER AGENCY AGREEMENTS

BOND AND BOYER STUDY (1988)

REVIEW OF 21 STUDIES BETWEEN 1963 AND 1985 MEETING CRITERIA

1) *INCLUSION OF CONTROL OR QUASI-CONTROL GROUP*
2) *INCLUSION OF SOME SPECIFIC FORM OF VR IN THE EXPERIMENTAL GROUP*
3) *PROGRAM FOR PSYCHIATRIC DISABLED OR STATISTICS FOR SUB SAMPLE*
4) *VOCATIONAL OUTCOME DATA PROVIDED*

SUMMARY OF FINDINGS

1) *IF OUTCOME EQUALS COMPETITIVE EMPLOYMENT RATE, 2 STUDIES YIELDED SIGNIFICANT RESULTS (AT THE END OF FOLLOW-UP PERIOD)*

   BELL AND RYAN (1984)
   MARX, TEST, STEIN (1973)

2) IF CRITERIA IS JOB STARTS IN CE, 4 STUDIES MIGHT QUALIFY

- SOME OVERALL ADVANTAGE TO EXPERIMENTAL GROUP

- STUDIES HAVE METHODOLOGICAL LIMITATIONS

CONCLUSION: NONE OF APPROACHES HAVE DEMONSTRATED EFFICACY IN HELPING CLIENTS ACHIEVE AND MAINTAIN CE OVER ANY SUSTAINED PERIOD OF TIME.

3) IF CRITERION IS PAID EMPLOYMENT (TE/SE)

8 OF 10 STUDIES INDICATE THAT:

(A) WHEN CLIENTS ARE GIVEN INTENSIVE SUPPORT AND ARE

(B) PLACED IN JOBS NOT TOO DEMANDING THEY OFTEN FUNCTION AT A LEVEL BEYOND USUAL EXPECTATIONS

- INTENSIVE SUPPORT -
- POSITIVE EXPECTATIONS -

CONCLUSION: GIVEN THE ADDITIONAL FINDING THAT EMPLOYMENT SUCCESS IS OFTEN NOT MAINTAINED AFTER TREATMENT ENDS, THEN SE PROGRAMS MAY BE THE BEST WAY TO INCREASE EMPLOYMENT RATES.

FINDINGS FROM 24 CONTROLLED STUDIES:

(Bond, 1992)

1. Vocational Rehabilitation programs have been consistently, although modestly, successful in helping clients obtain and hold jobs.

2. Few studies find an experimental effect for competitive employment rates.

3. Subjects in experimental (VR) conditions had significantly less hospitalization in over half the studies, BUT also received additional services not provided to control subjects.

4. Sheltered workshops are ineffective in producing competitive employment.

5. Clients with better work experience and better psychological adjustment benefit most from enriched vocational programs.

6. Clients with little/no work experience did most poorly regardless of type of vocational training provided.

7. Persons with mental illness have a good chance of retaining community employment as long as INTENSIVE SUPPORT CONTINUES.

FIVE (5) CURRENT APPROACHES TO VOCATIONAL REHABILITATION:(Bond, 1992)

1. BOSTON UNIVERSITY'S MODEL

* Extended pre-vocational preparation period

* Two intervention strategies:
(1) Client skill development
(2) building supports needed for functioning in a specific environment

+ Emphasis on client choice & career development ("Choose - Get - Keep" model)

+ Well Articulated Model

- Has not been empirically validated

- Does lead to > satisfaction with career choices but no evidence this leads to better employment outcomes.

2. JOB CLUB MODEL - (Azrin, 1979)

* Intensive behavioral counseling program focused on job finding

* Job finding viewed as involving interpersonal skills, a social info. network, and motivational factors.

+ Stresses client responsibility

+ More direct strategy for higher functioning clients

+ Positive empirical findings - produces as high as 90% employment rate

- Inadequate for lower functioning Clients

- Job retention rate is unclear

3. ASSERTIVE COMMUNITY TREATMENT (ACT) MODEL - (Stein & Test, 1980)

* Assertive outreach & service coordination to help clients in their natural environment

+ Closest to individual placement model of SE

+ Adaptable for small & rural programs

+ Promising controlled research

- Cost effectiveness is unclear

- Underdeveloped voc. capacity

4. PSYCHOSOCIAL REHABILITATION (PSR & TRANSITIONAL EMPLOYMENT (TE) - (Fountain House)

* Principles of normalization & gradualism

* Address client's basic needs & stress client responsibility well-defined

+ Well-defined model, national network

+ Long track record, refined methods

- Step to competitive employment hard, clients develop an institutional dependency on prevocational work crews

- Null findings from controlled studies

- Narrow, rigid stance toward employment options; job belongs to agency, not member (only 15% of TEP's convert to permanent jobs)

5. JOB BANK EXTENSION OF TE - (Thresholds, Rise, Incentive Community Enterprises)

* Range of type & level of job opportunities & cooperating employers

* Skill training programs & "supported education" options

+ Eclectic - Menu of Employment Options

+ Network & Cooperate with many Employers

- Takes Years to Establish

- Better Suited to Urban than Rural

- No Published Evaluation Studies

6. SUPPORTED EMPLOYMENT (SE)

Bellamy, Wehman (1986), Place-Train. (Developmental Disabilities). Federal Guidelines (1987)

* *"Place-Train-Plus": Advocacy, job development & placement, on- and off-site training ("coaching"), ongoing supportive services*

* *Competitive employment, integrated work setting, ongoing supportive services*

+ *Reconceptualization of problem from client (disability) to societal focus (unemployment)*

+ *Normalizing experience - real work for real pay*

+ *Zero reject - even the most severely disabled can work*

+ *Time unlimited, diverse supportive services*

- *Mixed results from evaluations of demonstration projects; 45-50% CE rate deteriorated after support withdrawn to base rate*

- *Used primarily with persons with mild or moderate mental retardation (72%) vs. long-term mental illness (14.6%)*

- *Nature, funding mechanisms, and responsibility for long-term support often problematic.*

INDIVIDUAL PLACEMENT & SUPPORT (IPS)

- Becker and Drake (1993), C.M.H. Journal
  NH - Dartmouth Psych. Research Center; Pitt

* Eclectic - "the best of the rest"

* CMH Center employment specialists - trained in MI, VR, employment and community resources

  + Rehab is MH's business
  + Client preferences
  + CE, integrated settings, follow-along supports
  + Continuous assessment, empirical research
  + Rapid job finding
  + Trusting, ongoing relationship

Favorable initial results:

	% Employment
CMHC day treatment program:	8
IPS:	55

GOAL: To Inform Trainees About Factors That Go Into The Provision of Quality S.E. Services for Severely Psychiatrically Disabled People In A Way That They Can Identify When Examining Program Options.

V WHAT ARE QUALITY SERVICES IN S.E. FOR PEOPLE WITH PSYCHIATRIC DISABILITIES?

There are many indicators that can be examined to assess "high quality" supported employment services. Materials put out by Paul Wehman et al (Virginia Commonwealth University), Tom Bellamy et al (University of Oregon), Bill Anthony et al (Boston University), Frank Rusch, John Tracht et al (University of Illinois) and Tom Powell et al (Corporation for Supported Employment in Connecticut). Quality services for people are quality services, period.

However, there is no denying that people with severe psychiatric disabilities do have some unique needs and face special barriers. What I have intended to do in the following section is to highlight some areas which are particularly important creating work opportunities for people with psychiatric disabilities - some of which are exactly the same as for any type of person but play out more prominently for these people: others which are essential to consider because of the stereotypes society holds of mentally ill people: others because of the nature of psychiatric disabilities. The intent here is not to label programs that do not meet these criteria as "bad" programs but rather to help identify potential gaps and problem areas when these are not met.

1) Integration and Visibility

There needs to be a concerted effort to ensure that supported employees are part and parcel of the regular work force and everyda society. Even more than concerns for numbers of clients at any worksite, there is a responsibility to be concerned that meaningful integration (i.e. to the extent the client wishes) occur in areas such as lunch, after hours socializing, employee training, etc. Because people with mental illness often have problems in developin meaningful interpersonal relationships (both because of their own behavior and societal stigma) the SE provider may need to provide advocacy with employers to insure this occurs - not settle for just a steady work opportunity. Also, a provider must recognize the ver real stigma attached to mental illness and be prepared to confront it even with employers who agree to provide SE jobs. One obvious way to combat stigma is the recognition that "front of the house" jobs (sales, waiters, etc.) do more to confront social stereotypes than "back of the house" functions (e.g. stock room, dishwashing, etc.).

2) Non-Stigmatizing Support

Because there does exist societal fear, stigma and guilt associat[illegible] with mental illness the nature of the support of the provider must allow for non-obtrusive interventions when needed. This may involve breakfast, lunch or dinner meetings, "undercover" (to employer), observations (e.g. job coach as customer), phone contact at night, etc.). Such "invisibility" is not always possible and/or even desirable. It is not a value in and of itself, but service providers should include it within the menu of options.

3) Prevention, Not Remediation, Is the Key

Almost by definition, the supports inherent in the concept of S.E. must of course be available to the worker quickly when crises do occur. But supports are best seen as preventive measures. All people undergo stress in making major life changes. The assumption must be that difficulties will arise for the client early on and intermittently throughout the job. A system of supports needs to be built in that is not totally dependent upon a client's identifying a need before an intervention is made. Sometimes clients lack the judgement to recognize problems early on; often employers do not give good feedback to employees with clear performance expectations, but rather give a sudden termination notice. Support, no matter where delivered, needs to be quite intensive during the 1st month and a minimum schedule of program initiated contacts needs to be maintained - obviously more if problems arise. The schedule I w[illegible]d recommend is the 1st, 2nd and 3rd days of employment, the end of [illegible]e 1st week; at least 3X the next week and 2X a week for at least the next 2 weeks; and then at least weekly thereafter. Once again, these supports can be individual meetings, phone contacts, group meetings, on and off-sites, etc. They can range from 10 minutes - 2 hours in length. What is crucial is they do occur and they are not dependent upon the identification of a "problem" for them to occur.

4) Comprehensive Involvement With Provider For Other Than S.E.

This concept reflects an ideal which may not always be feasible but because of the nature of a particular local service delivery system needs to be kept in mind. The nature of support is personal and caring, not technical assistance. It is difficult for people to provide the level of support people need during a difficult period in their lives (i.e. starting work) when there is no meaningful relationship behind the provision of that support. When persons want to seek solace, they do not look under "S" in the Yellow Pages (for support or solace); they turn to someone they know and trust (lover, spouse, family members, etc.) if that resource is available I believe the most effective service delivery models of S.E. for persons with severe mental illness are the psychosocial clubhouse and the Fairweather Lodge concepts where people can form caring relationships to use when needed. Sometimes these services don'[illegible] exist in a given area or clients do not choose this option. In that case, an independent S.E. provider must develop a mechanism for ensuring that relationships are developed between job coach and S.E. workers before a job site is obtained. A relationship that transcends the work place contact.

5) Rehab Planning Is Comprehensive in Nature

Programs that have experience in offering work opportunities for people with severe mental illness have consistently found that non-work areas of people's lives cause as much, if not more, work for the job coaches and support staff as work problems do. When developing a plan for S.E., it is essential that rehab counselors, case managers, program providers, clients and significant others include in the plan of action, strategies for dealing with other facets of the clients' life (treatment, housing, family problems, etc.). When running a S.E. program, providers and agency staff cannot arbitrarily divide problems as work and non-work related problems. A person's life impinges on his (her) work and vice versa. While work is important, it is not a panacea for solving problems associated with severe mental illness.

6) Cooperation Among Service Providers

Related to Number 5 above, such comprehensiveness in planning cannot be achieved without working at cooperation among service providers and significant others involved in the client's rehab. There are some issues which have to be confronted head on and will be addressed in another section on "Teamwork". But particularly VR counseling and MH case management staff must understand that there will be stress and strains associated with joint planning and programming.

Several dangers exist. Much emphasis in the literature has been placed on client "splitting" but there is a phenomenom entitled the "Stanton-Schwartz" syndrome wherein two helpers' disagreements "split" the client. It is not necessary to always agree nor even to avoid presenting competing alternatives for clients. It is necessary to be clear on the rationale for alternatives and not make the client choose among people, as opposed to courses of action.

Traditionally, VR people have placed a higher value on convening meetings among caregivers than others. However, they often take the perspective of laying out the limits of their responsibility at these meetings (i.e. "We're only a vocational agency") rather than the possibilities. On the other hand, DMH Case Managers often feel too busy to participate and/or can be impatient in looking at goals and outcome measurements for success - they just want to give a client a chance or even just obtain a disposition. Both stereotypes have grains of truth which both VR and DMH people must recognize, in order to dispel - not just resent the other's viewpoint.

GOAL: To Help Trainees Sort Out Some Of the Special Needs That Impact On A SE Program Serving People With Severe Psychiatric Disabilities.

VI WHAT ARE SOME SPECIAL CHARACTERISTICS OF S.E. PROGRAMS FOR PEOPLE WITH SEVERE PSYCHIATRIC DISABILITIES

While the similarities outweigh the differences (insofar as the core values are concerned) there are a few special considerations that are very clear differences in SE as it has developed for mentally retarded persons as opposed to SE for persons with severe and prolonged mental illness.

1) The Issue of Stigma with the Attendant Greater Need For Employer Advocacy

Psychiatrically disabled people are feared, stigmatized, rejected and discriminated against more overtly than mentally retarded people. There is more social acceptance of this attitude towards people with mental illness than for others. An S.E. program for this group must accept an advocacy role (occasionally adversarial) with employers. Program providers must not participate in employment discrimination (i.e. not screen out clients for reasons employers are not legally allowed to) and must see community education as a part of their roles.

2) There Is Often Personal Discomfort On the Part of the Provider Staff

Staff of providers are not immune to societal stereotypes and biases against psychiatrically disabled people. In fact, many psychiatrically disabled people are difficult to relate to for a variety of reasons. The nature (cyclical) of the illness is such that staff will not have a sense of easy completion; there is always the uncertainty of a psychiatric exacerbation; and clients with psychiatric disabilities are much harder to market as employees to business people.

A SE program that serves severely psychiatrically disabled people probably needs to spend more time in recruiting staff due to the "burnout" factor, aggressively counter erroneous stereotypes propogated within its own staff (e.g. "these people can fly off the handle at any time") and be extremely vigilant about what gets communicated to the public at large and potential employers via brochures, TV and radio spots, and face-to-face meetings.

3) Psychiatrically Disabled People Probably Have a Greater Sense of Lost Potential.

I do not wish to overstate this point in relation to mentally retarded people. But, SE programs for people with psychiatric disabilities often are dealing with people who have been exposed to vocational development activities through adolescence, whose progress was then hindered by the development of the mental illness. People with severe psychiatric problems have probably had some (albeit usually unsuccessful) work experiences in the outside world. They have probably been encouraged more than mentally retarded people to think about career options and to have experienced a sense of loss at not attaining them. While many SE jobs are probably more stimulating and socially enhancing than work offered to mentally retarded people in rehab facilities or developmental achievement centers, the reverse is frequently true in terms of psychiatrically disabled people's pre-SE vocational experiences.

4) Greater Worry About Labelling

Once again, as with Number 3 above, there is a tendency to exaggerate this difference in programs serving mentally retarded vs mentally ill people. There does appear to be greater self-consciousness as a rule about the need for overt manifestations of support, particularly on the job site when doing SE for persons with severe mental illness. Hence the concern about non-obvious support interventions as opposed to the 1-1 job coach model so prevalent in many of the current SE programs developed out of the mental retardation field. This is not to say that 1-1 on site support is not needed or wanted by many psychiatrically disabled people (the Fountain House TEP model and others dispel that notion) but rather program providers cannot take for granted the concept that the job coach/support person will be seen as more of a help than a hindrance. Client resistence to this 1-1 approach needs to be appreciated as a natural (and probably acceptable) skepticism and accepted, if at all possible. Certainly, it should not necessarily be seen as unrealistic concerns, pathological manifestations, or lack of motivation.

5) Parent Expectations Caused By Guilt and Social Stigma

Any parent of a disabled child or adult has totally warrented concerns about the nature and quality of services offered to his (her) son or daughter - no matter what the disability label. In the case of clients with mental illness, for a long time, parents, particularly mothers, have been scapegoated as causative factors (the schizophrenogenic mother) in the development of the disease. So this natural skepticism is augmented by societally reinforced guilt and the stigma that mental illness holds. It is to combat

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these attitudes, in addition to advocate for better services for mentally ill people that the National Alliance for the Mentally Ill has grown exponentially over the last few years.

Parent expectations for even non-disabled children are often unburdened, as they should be, by "realistic" limitations. In the case of SE for people with severe psychiatric problems, these expectations may run counter to the options that programs may have to offer. Also, as noted before, in the case of adults, client and parent needs are often complementary but never identical. This tension is exacerbated by the need for confidentiality and client control of his (her) own rehab. process.

Program providers need to give credence to parent concerns while not seeming to back away from their primary relationship responsibility - which is the client one. Program staff should not minimize differences of opinion nor try to imply parents should be realistic and accept what is there. They also should be clear when they are acting on the client's wishes, as opposed to deferring to the parents when disagreements occur.

Bond, Gary R. (1992). Vocational Rehabilitation. In R. P. Liberman, M.D. (Ed.), Handbook of Psychiatric Evaluation (pp. 244-275). New York: Macmillan Publishing.

CHAPTER 11

VOCATIONAL REHABILITATION

Gary R. Bond

This chapter provides a glimpse of the past, present, and possible future of vocational programming for persons with severe mental illness. To use a historical metaphor, the post-deinstitutionalization period can be divided into three eras: the rule of imperial institutions, the dark ages, and a renaissance. The first era started in the 1950s and extended into the 1960s. Vocational programs were implemented in hospitals, sheltered workshops, and halfway houses (Black, 1988). However, the optimism that prompted these facility-based efforts was soon overtaken by a deeply felt pessimism about the employment potential for psychiatric patients.

The 1970s and early 1980s were the "dark ages," in which vocational rehabilitation for persons with severe mental illness was not considered the mission of either community mental health centers (CMHCs) or comprehensive rehabilitation centers. During this time, psychosocial rehabilitation (PSR) centers, such as Fountain House (New York) (Malamud & McCrory, 1988; Vorspan, 1988), Thresholds (Chicago) (Dincin, 1975), Horizon House (Philadelphia) (Cnaan, Blankertz, Messinger, & Gardner, 1988), and the Club (Piscataway, NJ) (Lehrer & Lanoil, 1977) developed transitional employment (TE) programs. These programs were seen either as "maverick" or as "model" programs, depending on one's ideology. They existed as isolated fiefdoms within pervasively nonvocational mental health systems. Adaptations of TE are only now becoming part of the services within community support programs (CSPs) in CMHCs.

Now we may be on the verge of a renaissance in the form of the supported employment (SE) movement (Wehman & Moon, 1988). SE represents a paradigm shift in vocational thinking. By advocating the placement of clients with minimal prevocational training in community employment and the provision of time-unlimited support, SE has led to explorations of employment possibilities for persons with severe disabilities. Whether these explorations shall result in enduring social inventions remains to be seen.

Vocational approaches for persons with severe psychiatric disabilities will be examined against this historical backdrop. Three general questions guide this chapter: (a) What vocational approaches are effective? To be deemed effective, a program must result in paid employment outcomes for its clients. (b) What exactly do these programs do? We urgently need clear, operational descriptions of program services. (c) For whom are different vocational approaches successful? An appreciation of the potential of vocational programs has been muddled by vague sample descriptions. We need to develop more precise and appropriate taxonomies to describe clients successfully served by various programs.

A LOOK AT THE PAST: PRIOR RESEARCH

The research literature on the effectiveness of vocational approaches in psychiatric programs was examined, including the rare occasions in which researchers reported client-treatment interactions. Researchers have not built a cumulative knowledge base, and it was therefore necessary to impose an external structure on a scattered literature.

Method

Inclusion Criteria

Evaluation studies were included if they met five criteria: (a) The study was conducted after 1955, the approximate date for the inception of deinstitutionalization. (b) The program evaluated had an explicit vocational component. Several studies have shown that nonvocational approaches with emphases on insight and improved social functioning do not generalize to better work functioning (Gunderson et al., 1984; Vitale & Steinbach, 1965; Wilder, Levin, & Zwerling, 1966). (c) The sample studied consisted solely of clients with psychiatric disabilities. Or, if a mixed disability sample was used, statistics were reported on a psychiatric subgroup. (d) Random assignment, or a close approximation, was used. Subject as own control, ex post facto matched group, and single-subject designs were excluded. (e) Employment outcomes were reported. Twenty-four studies were located that met the requirements, as listed in Table 11.1.

Typology

Vocational programs were grouped into the seven categories briefly described below. The last three approaches (the job club, assertive community treatment, and psychosocial rehabilitation) are discussed further in the section, A Look at the Present: Current Popular Approaches, p. 251.

1. *Hospital programs* included those in which the participants were inpatients, regardless of whether the vocational programming occurred in the community or in-hospital.
2. *Halfway houses* included programs in which the primary site of rehabilitation was conceptualized as a community residence. The best-known model was the Fairweather Lodge, which provides a structured setting for living, employment, and peer support (Fairweather, Sanders, Maynard, Cressler, & Bleck, 1969).
3. *Sheltered workshops* included programs in which training and employment were provided by securing subcontract work from industry (Black & Kase, 1986). The vocational activity generally occurred in segregated facilities. Programs included comprehensive rehabilitation centers offering training to a range of disability populations (Weinberg & Lustig, 1968) and workshops specifically designed for clients with psychiatric disabilities (Meltzoff & Blumenthal, 1966).
4. *Vocational counseling* included programs in which the primary activity evaluated

Table 11.1. Controlled Studies of Vocational Programs for Persons with Severe Psychiatric Disabilities

PROGRAM TYPE	STUDY	SAMPLE SIZE		FOLLOW-UP PERIOD (MONTHS)	EXPERIMENTAL COMPARISON
		EXPERIMENTAL	CONTROL		
Hospital programs	Paquette & Lafave (1964)	140	140	Not stated	Halfway house and vocational training vs. custodial
	Becker (1967)	25	25	8	Intensive social/vocational program vs. custodial
	Walker et al. (1969)	14	14	6	Community transitional employment (TE) vs. hospital job placement
	Marx et al. (1973)[a]	19	20	5	Progressive inpatient vs. regular ward
	Kuldau & Dirks (1977)	41	48	18	Day hospital and workshop vs. rapid discharge
	Ryan & Bell (1985)	31	26	6	Hospital and community job placements vs. traditional inpatient
Halfway house	Fairweather et al. (1969)	57	48	12	Lodge vs. aftercare
	Lamb & Goertzel (1972)	28	20	24	High expectation halfway house vs. low expectation family care
	Velasquez & McCubbin (1980)	36	36	6	Community residence vs. waiting list
Sheltered workshop	Meltzoff & Blumenthal (1966)	33	36	18	Day treatment with workshop vs. psychotherapy
	Soloff (1967)	55	91	12	Sheltered workshop vs. state hospital or recreation therapy

	Weinberg & Lustig (1968)	20	18	24	Sheltered workshop vs. vocational counseling
	Griffiths (1974)	14	14	18 (mean)	Sheltered workshop vs. aftercare
Vocational counseling	Briggs & Yater (1966)	74	60	13 (mean)	Vocational counseling vs. no treatment
	Purvis & Miskimins (1970)	99	50	not stated	Group and individual counseling vs. no follow-up
	Kline & Hoisington (1981)	10	10	6	Career exploration at a psychosocial rehabilitation (PSR) center vs. PSR only
Job club	Azrin & Philip (1980)	19	6	4	Job club vs. vocational lecture
Assertive community treatment	Marx et al. (1973)*	21	20	5	Assertive community treatment (ACT) vs. hospital
	Field et al. (n.d.)	18	18	18	Job developer + ACT vs. sheltered work + ACT
	Stein & Test (1980)	57	59	12	ACT vs. short-term hospital and aftercare
Psychosocial rehabilitation centers	Beard et al. (1963)	163	69	12	PSR with TE vs. waiting list
	Wolkon et al. (1971)	106	185	12	PSR vs. aftercare
	Dincin & Swift (1969)	160	76	24	PSR + TE vs. PSR day program only or no services
	Dincin & Witheridge (1982)	46	44	9	PSR + TE vs. social club
	Bond & Dincin (1986)	56	54	15	PSR + rapid placement vs. PSR + gradual placement

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*This study is listed twice. It had two hospital control groups, which have been treated as separate experiments in the ensuing analyses.

was verbal interaction, in either a one-to-one or group format. Vocational counseling typically involved identification of client needs, development of a rehabilitation plan, and career selection (Farley, Schriner, & Roessler, 1988; Rubin & Roessler, 1978).

5. *Job club* included programs in which a behavioral approach was used to help any unemployed group acquire and use the skills needed to obtain jobs (Azrin & Besalel, 1979).

6. *Assertive community treatment (ACT)* was an approach consisting of helping clients in their natural environment with frequent home and community visits, and assisting clients to obtain funding, housing, and jobs on a time-unlimited basis (Stein & Test, 1980).

7. *Psychosocial rehabilitation (PSR) centers* included programs that evolved from the clubhouse model developed by Fountain House in New York (Beard, Propst, & Malamud, 1982; Dincin, 1975). They provided an accepting peer-oriented clubhouse. They also offered a continuum of vocational opportunities, ranging from prevocational work crews, usually unpaid, work opportunities within the center, to TE, which consists of temporary community jobs employing clients under an arrangement between the PSR agency and a community employer.

Outcome Measures

Six variables measuring paid employment were examined: employment status at the end of the follow-up period (either *paid* or *competitive* employment), *duration* (number of weeks worked), *earnings, job starts* (i.e., any community employment at any time during study period), and *intensity* (i.e., full-time competitive employment status). Paid employment included competitive, transitional, and sheltered employment.

Findings from 24 Controlled Studies

Study Characteristics

The classification of studies is shown in Table 11.1. The median publication dates for the studies reviewed in each of the seven vocational program categories showed an approximate temporal progression from institutional to industry-integrated approaches: sheltered workshop (1967), hospital programs (1971), halfway houses (1972), vocational counseling (1970), PSR (1971), ACT (1980), job club (1980). The mean study sample size was 104 subjects and the mean study follow-up period was 12.5 months. The studies had various methodological problems, including vague descriptions of both experimental and control treatment conditions, low statistical power, brief follow-up periods, ambiguities about when vocational programming was terminated, and high dropout and refusal rates (Bond, 1988).

Vocational Outcomes

Vocational programs have been consistently, although modestly, successful in helping clients obtain and hold jobs, as shown in Table 11.2. When meta-analytic techniques (Rosenthal, 1984) were used to evaluate the findings for this group of studies, the experimental condition showed greater vocational gains than controls on all six of the vocational outcome variables, as shown in Table 11.3. However, it is also true that none of the 13 studies reporting competitive employment outcomes found an experimental effect when examined individually.

Hospital Outcomes

Clients assigned to the experimental conditions had significantly less hospitalization than controls in over half the studies examining this outcome. However, in addition to vocational programming, these experimental groups received other services not provided to the control group. The studies were designed this way because they were not intended to evaluate the vocational intervention in isolation from all other services. Thus, this set of comparisons does not directly test the efficacy of vocational programs in preventing rehospitalizations.

Table 11.2. Frequency of Significant Findings on 7 Outcome Measures Favoring Experimental Conditions Among Studies Reported in Table 11.1[a]

	OUTCOME VARIABLE						
PROGRAM TYPE	PAID EMPLOYMENT	COMPETITIVE EMPLOYMENT	FULL-TIME EMPLOYMENT	JOB STARTS	DURATION	EARNINGS	HOSPITAL ADMISSIONS
Hospital-based	2/3	0/3	2/4	2/3	2/3	2/3	2/5
Halfway house	1/2	–	0/1	–	2/2	–	2/3
Sheltered workshop	–	0/4	–	1/2	0/2	–	1/1
Vocational counseling	0/1	0/1	–	–	0/1	–	–
Job club	–	–	–	1/1	–	–	–
Assertive community treatment	2/2	0/3	1/2	–	1/2	1/2	2/3
Psychosocial rehabilitation	0/4	0/2	1/1	1/2	1/2[b]	0/2	2/5
Total	5/12	0/13	4/8	5/8	6/12[b]	3/7	9/17

[a] The first number in each pair is the frequency of studies significantly favoring experimental condition. The second number is the total number of studies examining a particular outcome variable.

[b] Control group in one study had worked significantly more weeks than the experimental group.

Table 11.3. Meta-Analytic Results for 24 Controlled Studies Reported in Table 11.1

VARIABLE	OVERALL Z-SCORE	NUMBER OF STUDIES
Paid employment	6.0**	12
Competitive employment	2.9*	13
Full-time employment	4.1**	8
Job starts	5.7**	8
Duration	4.3**	12
Earnings	2.8*	5
Rehospitalization	6.2**	14

Note: All z-scores favor the experimental conditions; $^{*}p < .01$; $^{**}p < .001$.

Client Factors

Three studies used prior work experience to classify clients (Bond & Dincin, 1986; Kuldau & Dirks, 1977; Ryan & Bell, 1985) and one study stratified clients on their general psychosocial adjustment (Meltzoff & Blumenthal, 1966). A simple dichotomy was used in each case; for example, Bond and Dincin (1986) classified clients as *work-experienced* if they had been employed continuously for at least 1 year before admission, and classified the remainder as *work-inexperienced*. All four studies found that clients with more work experience (or better adjustment) benefited significantly more from the enriched vocational programs than did controls. Clients with little or no work experience did poorly regardless of the vocational training provided.

Discussion of the Literature Review

Early reviews by Anthony and his colleagues (Anthony, Buell, Sharratt, & Althoff, 1972; Anthony, Cohen, & Vitalo, 1978) documented a lack of differences in employment rates for clients attending vocational programs compared with baseline rates for this population. The current review qualifies this conclusion. It shows that these programs *have* succeeded in placing clients in jobs and in helping clients retain these jobs. The consistent deficiency of these programs has been their failure to prepare clients for future competitive employment outside the support provided by the rehabilitation program. Thus, the success of vocational programs has been in helping clients adjust to a specific vocational environment, which has sometimes been sheltered or transitional employment. Given what is known about the psychiatric population, it is not surprising that these skills have not generalized to new environments. Extrapolating from these data, one hypothesis is that clients have a decent likelihood of retaining community employment positions as long as they continue to receive intensive support.

Research on the effectiveness of sheltered workshops for persons with severe mental illness stopped in the United States after 1968. This was in contrast to the half-dozen active research programs in the 1960s (Black, 1988; Criswell, 1970). The reason that this line of research was abandoned is quite simple: Sheltered workshops have been ineffective in helping clients with psychiatric disabilities achieve competitive employment.

Among disability populations, clients with psychiatric disabilities do especially poorly in sheltered workshops (Ciardiello, 1981). The larger issue, however, is the poor track record these facilities have for placing in competitive employment clients with *any* disability. A national survey found that only 10% of workshop clients were placed in competitive employment annually (Greenleigh Associates, 1975). Bellamy, Rhodes, Bourbeau, and Mank (1986) have estimated that clients with mental retardation (MR) who are placed in day activity and work activity centers require an average of 47 years to "graduate" to competitive employment.

This points to the need to "triage" the vocational needs of the psychiatric population in a more meaningful way than has been done in the past. For example, the generally positive results from controlled studies of hospital-based programs illustrate the capacity for institutionalized patients for work, and to a greater extent than is sometimes acknowledged. Industry-integrated programs for long-term patients are possible, and should be encouraged when discharge is not a current option (Forman, 1988). At the other end of the continuum, the evidence is compelling that many clients with prior work experience can benefit from high expectation programs. Another subgroup not adequately served by existing programs consists of well-educated clients who aspire to more than entry-level jobs (Collignon, Noble, & Toms-Barker, 1987).

Finally, the subgroup that is perhaps least understood and who may benefit the least from existing programs are clients with little prior work experience. The current experimentation with "supported education" may prove to be an optimal pathway to employment for clients not suited for traditional programs (Unger, Danley, Kohn, & Hutchinson, 1987).

Overall, experimental clients had a *lower* hospital rate than controls in the studies reviewed. The inference, therefore, is that most clients who receive vocational programming within a comprehensive rehabilitation program have no greater risk of rehospitalization than those who are not involved in a vocational program. This conclusion is somewhat at odds with that reached by Test (1984) and Hogarty et al. (1986) for high expectancy programs in general. There are, in fact, examples in the literature (Goldberg, Schooler, Hogarty, & Roper, 1977; Lamb & Goertzel, 1972) in which some clients had poorer outcomes in high expectancy programs. Further research is needed to delineate client and treatment combinations in which high expectancy vocational programs are contraindicated. One characteristic of successful programs may be that they attend to the warning signs of relapse (Herz, 1984) and provide additional support or crisis intervention at those times. Successful programs may also assist clients in a graded, incremental trajectory of rehabilitation as well as in avoiding too many major life changes at the same time.

Comparison between different vocational approaches is difficult, because of the different populations each typically serves (Black, 1988). Research is needed to determine, for example, whether clients served by sheltered workshops differ systematically from those attending PSR programs, as has been sometimes argued. Such research would clarify whether different success rates are a result of sampling differences. Only a few of the studies reviewed used "grand prix" designs (Gottman & Markman, 1978) that pitted one approach against another. This research strategy has the unfortunate side effect of heightening competitiveness in a field in which cooperation is an essential ingredient of success. Perhaps quasi-experimental designs (e.g., Lam, 1986) are a partial answer.

A LOOK AT THE PRESENT: CURRENT POPULAR APPROACHES

Table 11.4 lists five vocational rehabilitation strategies currently being used in the United States. Although a few controlled studies have been conducted on these models, as described in the last section, many gaps remain in our knowledge. The following summaries are impressionistic, and the conclusions may well change as more data accumulate.

Table 11.4. Current Vocational Approaches in Psychiatric Rehabilitation

PROGRAM APPROACH	EXAMPLES	STRENGTHS	WEAKNESSES
Boston University psychiatric rehabilitation model	Transitional Employment Enterprises, Boston	Well articulated Emphasis on client choice	Lengthy prevocational preparation Not empirically validated
Job club	Brentwood Job Club, Los Angeles	Stresses client responsibility Most direct strategy for higher functioning clients Positive empirical findings	Not suitable for lower functioning clients Job retention unclear
Assertive community treatment	Program for Assertive Community Treatment, Madison, Wis, Harbinger, Grand Rapids, Mich	Closest to Wehman's Individual Placement Promising controlled research Adaptable to small programs Wide range of clients served	Cost effectiveness not clear
Psychosocial rehabilitation/ transitional employment	Fountain House	Clear model National network Long track record	Null findings from controlled studies Step to competitive employment hard
"Job bank" extensions of transitional employment	Thresholds Rise, Minneapolis, Minn, Incentive Community Enterprises, Mass	Menu of job options Eclectic – both Place-Train & Train-Place Wide range of clients served	Takes years to establish More suitable for urban areas No published evaluations

Boston University's Psychiatric Rehabilitation Model

At the Boston (BU) Center for Psychiatric Rehabilitation, Anthony and his colleagues have been developing a conceptually grounded rehabilitation approach that has roots in both client-centered therapy and skills training (Anthony, 1980; Farkas & Anthony, 1989). Unlike the other four current approaches described in this section, the Boston University (BU) psychiatric rehabilitation model has developed in an academic setting.

In a quasi-experimental evaluation of the BU psychiatric rehabilitation model, Goering, Wasylenki, Farkas, Lancee, and Ballantyne (1988) examined 2-year outcomes for 82 clients, comparing experimental subjects to historically matched controls. The experimental treatment was a case management program, using case managers trained according to the Boston model. The rate of paid employment was 20% for the experimental group, compared with 13% for controls, a nonsignificant difference. However, using a measure of "instrumental role," defined as ability to function as worker, student, volunteer, or homemaker, significantly more of the experimental subjects than controls were rated as successful.

Danley and Rogers (1989) have further articulated the vocational aspect of the BU model as entailing a *Choose-Get-Keep* sequence. Transitional Employment Enterprises (TEE), an agency experienced in providing vocational training to a range of vocationally disadvantaged clients, adopted the Choose-Get-Keep model in a new project designed for persons with severe mental illness (Trotter, Minkoff, Harrison, & Hoops, 1988). The BU model emphasizes extended exploration of career options before community placement. Accordingly, TEE's program included two phases of preemployment training, averaging 2 to 6 months, before clients graduated to the job-seeking phase. An evaluation of their program showed that 35% of program participants obtained competitive employment. Role functioning in nonvocational life domains did not predict successful placement.

The strength of the BU model is its focus on client choice, an emphasis that has been overlooked in many vocational programs. One effect of this counseling focus has been to enable clients to feel more satisfied with their vocational choices (Goering et al., 1988). Other studies suggest that a focus on career development increases client involvement in the rehabilitation process (Farley et al., 1988; Kline & Hoisington, 1981). Career exploration seems especially appropriate for addressing "career immaturity" that characterizes a significant subset of clients with severe mental illness (Ciardiello & Bingham, 1982). Poor job retention rates occur partly because clients are placed in jobs they do not choose. Often these are dead-end jobs that they find demeaning.

One indication that client preferences have been neglected is their absence in the empirical literature. The next generation of evaluations will undoubtedly examine quality of life, quality of the work place, and client satisfaction (Schalock, 1988).

A drawback to the BU model is its untested assumption that extended prevocational career exploration will lead to better outcomes. What has been shown to date is that career exploration leads to greater satisfaction with choices. However, satisfaction with choices is different from success in employment, as noted by Bolton (1988): "Vocational interests are relatively independent of the abilities that determine occupational success" (p. 180). More research is needed to determine how success and satisfaction can be jointly maximized.

Job Club

The job club is an intensive behavioral counseling program based on Skinnerian principles. The focus is on job finding with clients taking ultimate responsibility for obtaining jobs. Job finding is viewed as involving interpersonal skills, a social information network, and motivational factors (Azrin & Philip, 1980).

The emergence of the job club in the 1980s as a major VR activity is consistent with the mounting evidence that the only counselor activities associated with successful VR closures are services in close proximity to the job search itself (Vandergoot, 1986). According to past surveys, rehabilitation professionals typically spend less than 10% of their time on placement-related activities, thus partially explaining low competitive employment rates for clients with severe disabilities (Vandergoot, 1986).

Azrin and Philip's (1980) initial study with a heterogeneous sample of unemployed persons reported extraordinary success rates for job club participants. For job club clients who had been in a mental institution, the employment rate was 90%, compared to 33% for controls. Job club clients "with mental problems" achieved a 94% employment rate. A replication reported that 42% of the job club members were placed in employment, compared with 13% of controls (Keith, Engelkes, & Winborn, 1977). Unfortunately, this study did not report separate statistics for different disability groups. Eisenberg and Cole (1986) compared veterans with mental illness participating in a job club with a demographically matched control group. During a 5-month follow-up period, 61% of the 26 experimental subjects had found employment, compared with only 10% of the controls, a significant difference.

A series of uncontrolled studies on the Brentwood Job Finding Club by Jacobs and his colleagues (Jacobs, Kardashian, Kreinbring, Ponder, & Simpson, 1984; Jacobs et al., 1988) provides the most extensive information on the application of the job club to the psychiatric population. A study with a Veterans Administration (VA) psychiatric population found that 56% of those entering the program obtained a job; 68% of those employed who were located after 6 months were still employed (Jacobs et al., 1984). In a subsequent study, 51% of all participants found vocationally productive placements (Jacobs et al., 1988). However, a third study obtained a more heterogeneous sample than the preceding two studies. In this last study, which included referrals from community-based treatment and residential care programs, the success rate dropped to 29% (Jacobs et al., 1988). VA referrals had a 37% success rate, compared to a 17% success rate for non-VA referrals. Moreover, only 12% of clients diagnosed with schizophrenia or bipolar disorder achieved employment, compared to 45% of the remainder, who had diagnoses of substance abuse, anxiety disorder, or depression. Recipients of Supplemental Security Income (SSI) had significantly poorer outcomes. Poor work history and poor interviewing also were negatively associated with employment. Thus, the job club is an excellent option for clients who are not overly disabled, but it is apparently an inadequate response for clients with severe psychiatric disabilities.

One drawback to the job club model is that it does not address job retention. Similarly, the job club literature has generally not reported job retention statistics beyond a short follow-up period. Moreover, documentation of program dropouts has been weak.

A logical extension of the job club model is use of behavioral strategies to improve job retention. Mueser and Liberman (1988) report a successful case study of a behavioral approach to helping a client acquire the social skills necessary to retain a job. A large sample controlled study of this individualized approach applied to vocational issues would be a major contribution to the literature.

Assertive Community Treatment

ACT includes programs in which assertive outreach and service coordination is used to help clients in their natural environment.

The prototype is the Program for Assertive Community Treatment (PACT) in Madison, Wisconsin, developed by Stein and Test (1980). Unlike facility-based models, PACT provides in vivo training in the activities of daily living.

ACT is widely regarded as a promising, commonsense approach. Its demonstrated efficacy in increasing community tenure is substantial. It is flexible, in that it can be adapted to both small and large programs. It is also well suited to rural communities (Rutkowski & Howick, 1986). Because the approach is individualized, clients with a wide variety of characteristics are appropriate for referral. ACT programs provide time-unlimited support, which is believed to be important for job retention. The ACT philosophy of defining client services as the responsibility of a single core team avoids the fragmentation that has hampered vocational initiatives.

Harbinger, a Michigan ACT program, was evaluated in a controlled study of 91 clients (Mulder, 1982). The study results are difficult to evaluate because of compromises made in the randomization procedure, the lack of a fixed follow-up period, and lack of details in the final report. However, it is the only controlled study outside of Madison of an ACT program with a vocational focus. Harbinger placed clients in volunteer positions in community businesses. Follow-up interviews were completed on 90% of Harbinger clients and only 56% of control clients. The difference in employment rates—26% for Harbinger clients and 18% for controls—was not significant. The mean annual earnings from employment was $537 higher for Harbinger clients than for controls.

Another controlled study of ACT found no differences in employment status between ACT clients and controls (Hoult, Reynolds, Charbonneau-Powis, Weekes, & Briggs, 1983). However, the description of the ACT program did not include any mention of a vocational emphasis.

Unfortunately, few ACT programs have developed their vocational capacity as extensively as the PACT program in Madison, so it remains unclear how easily the vocational aspect of the ACT model can be replicated. Finally, the cost effectiveness of the ACT model's individual placement approach to employment remains an open question.

Psychosocial Rehabilitation and Transitional Employment

PSR developed out of a self-help group for ex-psychiatric patients (Dincin, 1975). Accordingly, it deemphasizes the patient role and stresses the client's own responsibility for rehabilitation. Clients are referred to as *members*, and the rehabilitation process stresses principles of normalization. Status distinctions between staff workers and members are often blurred. PSR programs attempt to address basic needs of members for housing, recreation, social support, and employment. Most PSR programs emphasize the principle of gradualism (Dincin, 1975). According to this principle, clients may move through a continuum in each of several critical life domains (such as employment, independent living, and socializing) in the process of achieving full integration in the community.

A key element in the vocational continuum is TE. Beard et al. (1982) have listed 18 formal characteristics of TE, including the following: The positions are temporary, and they "belong" to the PSR agency, not the members. Members typically work half-time, in entry-level jobs in community settings. Job failures are accepted as part of the vocational process, and members may work many different TE positions.

PSR is a well-defined model with a strong national network. These are valuable characteristics for implementation and community acceptance. The long history of PSR suggests that it has survived a trial-and-error process during which its methods have been refined.

Several recent surveys suggest the extent to which the PSR model has been disseminated. Stratoudakis (1986) has reported 178 clubhouses modeled after Fountain House. Rutman and Armstrong (1985) surveyed 114 TE programs and found that among clients completing TE, 35% were employed and 16% were on another TE placement. One of the key findings was a fair degree of fidelity in emulating the Fountain House model among those programs surveyed.

One drawback to PSR programs is that clients develop an institutional dependency on the prevocational work crews (Bond & Boyer, 1988). Some studies have suggested that PSR clubs have difficulty moving the majority of clients beyond prevocational activities. A Maryland survey of 28 PSR centers found that only 5% of their clients were placed in competitive employment in a 12-month period (Connors, Graham, & Pulso, 1987). A case study of one PSR program found that clients had alternating cycles of progress and regression, and that they returned more frequently to prevocational crews than to any other program component (Turkat & Buzzell, 1982). Clinical impressions suggest that the step from TE to competitive employment may simply be too large for some clients.

The nonexperimental evidence on the efficacy of the PSR and TE models is equivocal: Some reports suggest competitive employment rates exceeding 40% for graduates (Rehab Brief, 1986; Ruffner, 1986). To what degree these figures are affected by self-selection is hard to judge. Moreover, none of the controlled studies of PSR have shown positive results for employment.

Another criticism of Fountain House and other clubhouses following its paradigm is that they have traditionally taken a fairly rigid stance to the kinds of agency-employer relationships they will undertake. For example, the TE model stipulates that jobs belong to the PSR agency, not the member. Consistent with this principle, Rutman and Armstrong's (1985) survey reported that only 15% of TE participants converted their TE position into a permanent job. Thus, the disadvantage of a clearly defined model is a tendency to rule out other options.

Job Bank Extensions of Transitional Employment

A label for the final type of vocational approach is approximated, although inadequately, by the term *job bank*. This approach is characterized by expansion of vocational services into a wide array of options, partly as a function of community business opportunities. The job bank capitalizes on relationships with a variety of cooperating employers. Employment specialists therefore already have a list of available employment possibilities when they begin vocational planning with a new or returning client. The menu of job opportunities the job bank affords its members distinguishes it from all the other models described above. Clients have the advantage of a range of options in terms of types of jobs, work schedules, duration of employment, and hours worked per week. Moreover, such programs offer relatively easy entry, exit, and reentry to new jobs.

Three agencies that exemplify this eclectic approach are Thresholds (in Chicago), Rise (in Minneapolis) (Barrett & Lavin, 1987; Prieve & DePoint, 1987), and Incentive Community Enterprises (in Massachusetts) (Campbell, 1988). Unlike Fountain House, these agencies have experimented widely with different vocational options. These agencies are pragmatic, and they have avoided a rigid ideology regarding the single "best" agency-employer arrangement.

For example, over the past 30 years many innovations have transformed the Thresholds vocational program from a clubhouse approach based on Fountain House to a complex and eclectic set of vocational strategies. A partial list of strategies includes a factory enclave (Bond, 1987; Forman, 1988), arrangements with local food services industries to supply them with trainees, supported employment opportunities, a mobile job support team, and special arrangements with community employers in which Thresholds, in essence, functions as an employment agency. In the realm of supported employment, Thresholds staff have been examining supportive roles for coworkers. A recent program development has been the Community Scholars Program, a "supported education" approach in which clients are assisted in the completion of university and technical school coursework. Thirty-six clients had enrolled in the Community Scholars Program by the end of 1988 (Thresholds Community Scholars, 1990). Thresholds also continues to have a strong TE program. In a 1986 survey of 135 agencies offering TE to persons with severe mental illness in the United States, Thresholds ranked first in the number of members on job placement, first in the total annual wages paid to members, and fourth in the total number of employers (Thresholds Newsletter, 1987).

The Rise program provides a similar range of options: enclaves, typically for lower functioning clients with multiple disabilities; training programs for data entry and for nursing assistant certification; and conventional TE (Barrett & Lavin, 1987; Prieve & DePoint, 1987).

Discussion of Current Approaches

These five vocational approaches vary on a number of critical dimensions. None emphasizes traditional psychometric assessment. The BU model employs a functional assessment approach that explores the skills necessary for a client to be successful and satisfied in the environment of choice (Anthony, Cohen, & Danley, 1988). The job club uses behavioral assessment to identify specific skill deficits in job acquisition. ACT stresses community-based assessments and job tryouts (Bond, 1987). PSR programs have used prevocational work crews as a context for situational assessments (Bond & Friedmeyer, 1987). The job bank agencies use a combination of strategies. Among the five approaches discussed, ACT is most similar to the individual placement SE approach, to be described in the next section.

With regard to prevocational training, the approaches vary from the BU model, which stresses extensive prevocational exploration, to the job club, which consists of only 20 hours of training prior to the job search. Empirically, PSR programs appear to have extended prevocational preparation for most clients. ACT and job bank programs are individualized and in theory are flexible about preparatory time.

As we look toward the future, Wehman's (1986) *place-train* paradigm may affect both the conceptualization and implementation of psychiatric vocational programs. Of the five current approaches presented, only the BU approach explicitly stresses the desirability of extended preparation in protected environments. Accordingly, programs adopting BU principles have not encouraged rapid entry of clients into community employment (Bond, 1990a).

Important comparative issues remain unanswered. What are the self-selection biases to the respective approaches? Clients with prior work history appear to do better, regardless of vocational approach, but are some approaches more adaptable? How easily can each approach be implemented in new areas? The clubhouse has had the widest dissemination. Is it incompatible with medically oriented CMHCs? How has the clubhouse been adapted? Aspects of the ACT approach have similarly been widely adopted, but the inclusion of a vocational counselor on the ACT team, as found in some Wisconsin CSPs, is rare. With regard to ongoing support, which approaches actually provide the necessary intensity of intervention? Only the job club approach explicitly excludes ongoing support from its program description. How cost-effective is each approach? Which approaches do clients prefer? This is only a sampling of questions that merit attention.

A LOOK AT A POSSIBLE FUTURE: SUPPORTED EMPLOYMENT

Definition of Supported Employment

Supported employment as defined by 1987 federal guidelines consists of three elements: (a) competitive employment (defined as employment paid at commensurate wages with an average of 20 hours of work per week), (b) an integrated work setting, and (c) the provision of ongoing support services (Wehman, 1988). The guidelines stipulate three types of integrated work settings, which have become known as (a) the individual placement approach, (b) the enclave, and (c) the mobile work crew (Moon & Griffin, 1988). These guidelines also state that SE is intended for "individuals who, because of the severity of their handicaps, would not traditionally be eligible for VR services" (Wehman, 1988, p. 5).

In the federal guidelines, TE is listed explicitly as a type of SE. Its inclusion in the SE guidelines was *political*, and not a conceptually elegant decision. The prospects for VR funding to SE programs explains the lobbying activity on behalf of the TE language.

Historically, TE has evolved quite differently from SE, although the motivations for the development of each are related. As previously described, TE was originally developed by Fountain House for persons with severe mental illness. By contrast, SE developed out of the normalization movement for persons with MR.

Definitionally, the chief distinction between SE and TE is that TE is *time-limited* whereas SE is not. Edelstein (1988) has noted three assumptions of TE not shared by SE: (a) prevocational training should precede placement, (b) clients should be able to function at the competitive production levels at the time of placement, and (c) follow-up supports are not permanent and ongoing.

Philosophically, there are points of convergence and divergence (Anthony & Blanch, 1987; Bond, 1987). Both SE and TE stress the importance of placing clients in real work settings, and both deemphasize traditional assessment approaches. TE, however, minimizes the importance of the job match for a TE client, because the TE work experience is valued as an opportunity to work and to earn money in an integrated setting. Because the job is temporary, the specific content of the job is less important.

The SE Movement

Wehman, Kregal, and Shafer (1989) have documented the growth of SE services in 27 states that received federal SE funding. According to their survey, these states reported serving 9,633 SE clients in 1986. By 1988 this number had grown to 24,817. The vast majority (72%) of 1988 SE clients had a primary disability of MR. However, 14.6% had long-term mental illness. Individual placements accounted for 65% of the 1988 placements, followed by the enclave (20%), the work crew (6%), and small businesses (4%). The most popular SE occupations have been custodial (35%), food service (23%), manufacturing (12%), and clerical (3%). The majority of clients (73%) met the federal guidelines by working at least 20 hours per week, although 40% of the individual placement clients did not. Hill's (1988) surveys suggest that SE programs have not fulfilled the intent of federal guidelines in that most SE recipients are only mildly or moderately disabled. Wehman (1988) has acknowledged this discrepancy.

To summarize, SE is a popular movement at present, probably fostered in part by economic conditions that brought a demand for new workers in the service sector. Campbell (1988) notes that supported employment involves a reconceptualization of the problem from a client to a societal focus. The problem is defined in terms of unemployment, not disability. Following this logic, the solution lies with local industries, *not* with human service organizations.

Although SE can be conceptualized as a program model, the existing literature has focused largely on the systems aspects implied by its introduction. This emphasis is not accidental because adoption of SE requires a radical shift in thinking in both the VR and MH systems. Moreover, the proponents of SE have been politically astute and sensitive to the problems of assimilation of new models into the existing VR system. Despite Wehman's assertions that SE is a movement for all disabilities, in most states it has remained focused mainly on the MR population. We now turn to efforts directed specifically at the psychiatric population.

SE for Persons with Severe Mental Illness

In 1978 a cooperative agreement was made between the Rehabilitation Services Administration and the National Institute of Mental Health to improve vocational services for the chronically mentally ill. This agreement led many state vocational rehabilitation (VR) and mental health (MH) departments to follow suit (Stratoudakis, 1986). Additionally, supported employment legislation provided funding for SE demonstration projects. In some states this funding resulted in projects targeting the psychiatric population (Rehab Brief, 1987).

Statewide SE projects aimed at the psychiatric population are a recent phenomenon, and virtually no statistical data on them are available. The early results from these demonstration projects have been mixed.

In 1983 Pennsylvania funded 33 "industry-integrated" projects at a cost of $2.5 million. During the first year of operation, 920 clients were served and 174 were placed. However, only 47 clients were rehabilitated, using VR criteria for successful closure. The second year brought a large increase in successful closures (Forbrich, 1986).

In 1983, the Ohio DMH initiated a study of vocational services for persons with severe mental illness (Saveanu & Roth, 1986). Over a 4-year period, 2,323 clients were rehabilitated, at an average per-client cost of $2601. Of the 7,164 clients referred, 71% were accepted for rehabilitation services. This is an encouraging rate because of the history throughout the United States of screening out clients believed to be too severely disabled. The fact that only 20% of the referrals came directly from the CMHCs suggested a major gap in the full implementation of the interagency agreement. In a survey of VR and MH practitioners, each tended to blame the *other's* system for implementation problems (Saveanu & Roth, 1986).

Indiana provided $1.2 million targeted for 10 vocational projects during 1986–1987. The guidelines for these projects included the requirements that they be "industry integrated, complement existing services, and lead to competitive employment" (Indiana, DMH, 1985, p. 1). The success in implementation of the 10 projects was mixed. Five were judged moderate successes, and five had major implementation problems.

Outcome Findings from an SE Demonstration Project

Nichols (1989) evaluated one of the 10 Indiana demonstration projects. It used an individual placement approach provided by Morgan County Rehabilitation Services (MCRS), a comprehensive rehabilitation center in central Indiana. The sample consisted of 25 clients who were followed for an average of 66 weeks after admission to the program. The clients were mostly referred from local CMHCs. Although the target population was intended to be clients with severe mental illness, the sample characteristics suggested that this population was less impaired than typical CSP clientele. For example, only 36% were SSI or Social Security Disability Income (SSDI) recipients and only 32% had a diagnosis of schizophrenia. Nevertheless, the majority of clients were severely disabled, as suggested by an average of three prior psychiatric hospitalizations and an average of only 1 month of employment in the preceding year.

During the study period, 80% of the clients were employed at least once, and 52% were employed at the end of the study period. Nineteen clients were employed at least once before the last month of the study period. They averaged 30.7 weeks of employment, earning an average of $2,616. They also averaged 28 hours of employment per week with an average hourly wage of $4.00. The average number of hours worked per week varied widely; 36% averaged fewer than the 20 hours per week stipulated by the federal definition of SE.

The 19 clients achieving competitive employment received an average of only 19.4 hours of job coaching, or approximately 40 minutes of job coaching per week of employment. Clients also averaged 75.9 hours of attendance in an employment support group. Number of hours of job coaching was negatively correlated with average number of hours worked per week. Thus, clients who worked full time had far less job coaching than those who worked only a few hours a week, as might be expected.

The "VR process" was a major interest in this study. MCRS conceptualized their program as consisting of two major phases, a *prevocational* phase and a *placement* phase. The prevocational phase was further sequenced into: *VR referral* (the time required for establishing the client's eligibility for VR services), *vocational evaluation*, and *work adjustment* (consisting of sheltered workshop and TE placements). Periods of time in which clients temporarily dropped out of the vocational program were classified as *hold* time. Hold status occurred for a wide range of reasons, including medication problems, attempts by clients to find jobs on their own outside the rehabilitation program, concerns about losing Social Security benefits, and requests by staff at the CMHC. Once in the placement phase, clients began the job search in collaboration with the job developer. The placement phase consisted of three types of activities: searching for jobs (*search*), working (*job*), and periods of inactivity (*hold*).

The average duration in each of the program phases for the sample of 25 clients is displayed in Figure 11.1. Time was apportioned as follows: prevocational phase (28%), searching for a job (19%), hold status (19%), and competitive employment (36%). The length of time spent in the various preparation phases was either unrelated, or negatively related, to vocational outcomes, after controlling for time in program. Thus, these data do not support the notion that an extended preparation time enhances one's job retention.

The obstacles to employment can be clarified by examining the apportionment of time across the various phases. Clients averaged 18.4 weeks in the prevocational phase before starting the job search. This delay is noteworthy, because the program was conceptualized as a rapid placement approach. Moreover, MCRS was the most committed of the 10 Indiana demonstration projects to reducing the administrative and other barriers to community employment. Specifically, MCRS streamlined the VR eligibility process and deemphasized both vocational evaluation and prevocational preparation. Thus the prevocational phase was *shorter* than in the other projects. Even so, the 4-month preparation period may be less than optimal.

After clients entered the placement phase, the process of vocational rehabilitation was not linear. Three factors influenced the stability of job tenure: hold status, job changes, and hospitalizations. Clients averaged 12.9 weeks in hold status, 91% of which occurred *after* they entered the placement phase. Twelve clients held two or more jobs. Three of the 25 clients were hospitalized during the study period.

Demographic and diagnostic variables had little bearing on either the rehabilitation process (as measured by length of time in the program components and amount of job

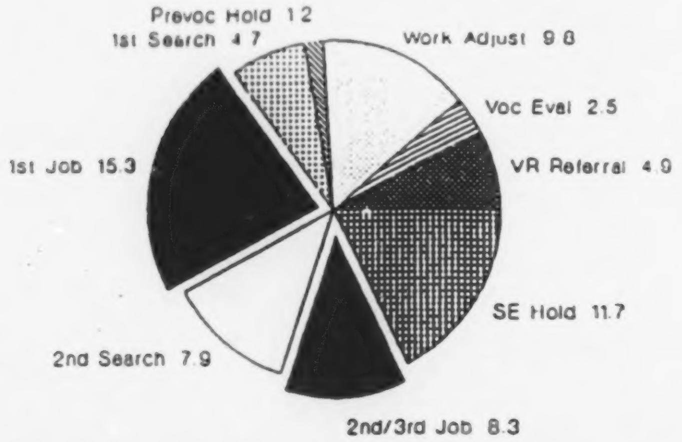

Figure 11.1. Average duration in SE phase. Average number of weeks spent in each vocational program phase for 19 clients with severe mental illness. *Note:* Values are weeks in each phase. SE = supported employment; VR = vocational rehabilitation; Voc Eval = vocational evaluation; Prevoc Hold = prevocational hold. (Adapted from Nichols, 1989.)

coaching and number of support groups attended), or on outcomes. SSI and SSDI recipients, however, had significantly poorer outcomes compared to nonrecipients.

Discussion of Supported Employment

The debate on the merits of SE for the psychiatric population has been obscured by a lack of hard data, conceptual confusion, and the confluence of *program* and *systems* issues. The Pennsylvania, Ohio, and Indiana projects suggest that systems change is slow. Others have also concluded that cooperation between VR and MH programs is problematic (Dellario, 1985; Noble & Collignon, 1988).

The Nichols study shows that achievement of competitive employment is difficult even when rapid placement is an objective. The barriers included both client resistance and administrative barriers. Client resistance became more salient when clients were closer to actual employment than when they were engaged in prevocational activities. As other studies have found, client resistance was also greater when clients were receiving Social Security benefits. Long-standing administrative barriers included those imposed by both the VR system, with its cumbersome eligibility process, and the MH system, with the lack of referrals.

Future research should differentiate SE approaches for clients with psychiatric disabilities from the approaches used with the MR population. One difference already widely reported is a different conception of job coaching with the psychiatric population than with MR clients. Quantitatively, clients with severe mental illness receive far less job coaching at the job site. For example, the average of 19.4 hours of job coaching in the Nichols study for an average 30-week employment period is far less than the 113-hour average during an initial 12-week training period for MR clients reported by Hill (1988), or the average of 233.2 hours reported more recently by Wehman et al. (1989). Supplementing the job coaching in the mental health system is case management. The empirical literature suggests that the consistency of follow-along support is instrumental in job retention (Bond, 1987), although this has not been shown directly for supported employment. Wehman (1986) has described SE as a *place-train* model. For the psychiatric population a more apt term may be *place/follow-along*, because the support does not typically involve job coaches training clients in job-specific skills.

The nonlinearity of the rehabilitation process observed in the Nichols study has also been noted by Strauss, Hafez, Lieberman, and Harding (1985). Insofar as SE provides time-unlimited support and allows for flexible arrangements in the number of hours clients work, it is well suited to the frequent and unpredictable variations in status characteristic of the psychiatric population. The finding that clients in the Nichols study were given a second and third opportunity for competitive employment is consistent with the Fountain House philosophy of tolerating job failures (Beard et al., 1982).

ONE FUTURE DIRECTION FOR RESEARCH: THE *TIMING* OF PLACEMENT

Wehman (1986) has hypothesized that a place-train sequence is more effective for persons with severe disabilities than the conventional train-place approach. This hypothesis should be tested directly, especially because it goes against the conventional VR wisdom. Not all experts agree that Wehman's hypothesis applies to the psychiatric population. In particular, the BU model represents a dissenting viewpoint (Anthony & Blanch, 1987).

One fact is apparent. If clients are to have rapid entry into integrated work experiences, employment specialists must take an assertive approach to both the VR and MH systems. To date, the main evidence that a place-train model is effective is based on demonstration projects showing reasonable placement and retention rates for MR clients who have had little prior competitive employment within the traditional sheltered workshop programs. The Thresholds accelerated placement study (Bond & Dincin, 1986), although conducted between 1980 and 1983 and therefore somewhat dated, offers the only direct experimental evidence on a rapid placement approach with any severely disabled population. For this reason it is described in some detail.

Method

Design

The design compared two vocational approaches designated as *accelerated* and *gradual*. Clients randomly assigned to the accelerated condition were placed in a TE position (typically an enclave) 1 month after admission to Thresholds. Clients in the gradual condition attended prevocational work crews for a minimum of 4 months before they were eligible for TE.

Sample Characteristics

The study eligibility criteria for clients were the following: (a) 18 years of age, (b) unemployed, (c) stated goal of employment, and (d) minimum attendance of 40 hours during the first 4 weeks at Thresholds.

In the sample of 131 clients accepted into the study, the mean age was 24.5. Modally, the clients were males (69%), whites (75%), and high school graduates (80%). Diagnoses, obtained by the client's case worker from the most recent hospital records, indicated 55% with schizophrenia, 19% with a major affective disorder, and 26% with a personality disorder. The sample averaged 3.2 prior psychiatric hospitalizations. At the time of admission, 61% were receiving government assistance (either SSI or SSDI), 31% were supported by their parents, and 8% stated they were self-supporting. The median number of years in prior competitive employment was 2 years. The median length of unemployment immediately prior to admission was 9 months.

Predictor Variables

Client background variables were obtained during an interview conducted 1 month after program admission. In addition to demographics, three employment variables were coded: work experience, months employed, and months unemployed. Work experience was a dichotomous variable distinguishing between clients who had worked 1 year continuously in competitive employment and those who had never done so. Months employed was defined as the time in paid employment before admission. Months unemployed was measured between the termination from the last job held and date of admission (with a value of 70 months assigned to those who had never worked).

Two types of staff ratings were obtained. At study admission, a research assistant made ratings on the Global Assessment Scale (GAS) (Endicott, Spitzer, Fleiss, & Cohen, 1976). A situational assessment, based on staff ratings of client work performance in prevocational work crews and TE placements, was obtained for 84 clients an average of 5 months after program admission (Bond & Friedmeyer, 1987). (Situational assessments were not obtained for early program dropouts.)

At study admission, clients made self-ratings of general capacity to cope with problems on a 7-point Coping-Mastery scale (Pearlin & Schooler, 1978). Clients also completed the Work Performance Inventory, a 22-item inventory of common obstacles to job retention (e.g., symptoms, lack of education, work conditions, work stress) adapted from Westermeyer and Harrow (1987).

Dropout status was coded as a 3-point scale, based on whether a client dropped out during the first 4 months in the program, dropped out between the fourth and ninth months, or was an active client of the program for the entire 15-month study period.

Vocational Outcome Variables

Three outcome variables were examined for 107 clients located for interviews 15 months after study admission. Employment status was based on the client's status at the time of the follow-up interview. A 5-point scale was used: (a) competitive employment, (b) individual TE placement, (c) group TE placement, (d) prevocational work crew, (e) unemployed. Weeks worked was defined as the total number of weeks of paid employment over the final 11-month period. Earnings referred to all wages earned during that time.

Findings from the Accelerated Placement Study

As shown in Table 11.5, the two most potent predictors of vocational success were dropout status and situational assessment ratings. The correlations for the dropout status variable are probably underestimates, in that employment information on many of the early program dropouts could not be obtained at follow-up. The third largest correlation in Table 11.5 was between assignment to experimental condition and weeks worked during follow-up.

Among the employment history variables, work experience was modestly correlated with vocational outcome, and length of unemployment was negatively correlated with earnings. Reception of government assistance was negatively correlated with outcome. Finally, education showed a marginal correlation with outcomes. Except for those variables already mentioned, client characteristics were not helpful in predicting vocational success. Hospitalization history, global functioning, and client's self-report were not correlated with outcomes.

Three Conditions Enhancing Vocational Success

The pattern of correlations suggested a post hoc representation of the findings based on the intuitive notion that the pathway to employment consists of a series of successive hurdles. The findings were organized around a division of the sample into five subsamples defined by an *approximate* chronological hierarchy, based on clients' progression through the program. This is diagrammed

Table 11.5. Predictors of Vocational Outcomes in Thresholds Study by Bond & Dincins, 1986

PREDICTOR VARIABLE	SAMPLE SIZE	15-MONTH EMPLOYMENT STATUS[a]	WEEKS WORKED	EARNINGS
Demographic Variables				
Age	107	.06	.10	.09
Sex[b]	107	.02	−.16	−.06
Race[c]	107	.10	.04	−.02
Education	107	.17	.19*	.15
Diagnosis, Disability, and Duration				
Schizophrenia/other	107	.15	.00	.03
Income assistance[d]	107	−.21*	−.21*	−.23*
No. of psychiatric hospitalizations	107	.04	−.07	−.11
Vocational Variables				
Work experience[a]	107	.21*	.23*	.20*
Months employed	107	.13	.09	.11
Months unemployed	107	−.18	−.10	−.20*
Staff Ratings				
Global assessment scale[a]	102	−.03	−.01	.08
Situational assessment[a]	77	.48**	.55**	.57**
Client Self-Ratings				
Coping mastery[a]	85	.03	−.02	.09
Work performance inventory[a]	103	−.08	.00	−.01
Vocational Program Variables				
Dropout status[e]	107	−.51**	−.46**	−.22*
Gradual/accelerated	107	.15	.38**	.21*

Note: Categorical variables were coded as follows for calculating Pearson correlations:

[a] Higher scores indicate better functioning.

[b] Sex: Male = 1, Female = 2.

[c] Race: White = 1, Black or Latino = 2.

[d] Income assistance: Self-support = 1, Parental support = 2, Government assistance = 3.

[e] Dropout status: Active for 15 months = 1, Terminated between 4 and 9 months = 2, Terminated within 4 months = 3.

*$p < .05$.

**$p < .001$.

in Figure 11.2. The first variable, labeled *persistence*, was defined by duration in the Thresholds program. Two subgroups of dropouts were defined: those who dropped out within 4 months and those who dropped out between 4 and 9 months. The second variable, labeled *performance*, was defined by staff ratings on the situational assessment. Among clients active for at least 9 months, those who scored below the median on the situational assessment rating were classified in this third group. The third variable, labeled *placement*, was defined by the experimental condition. Two groups were identified among clients who were active for at least 9 months and who scored above the median on the situational assessment: those who were randomly assigned to the standard gradual program with prevocational preparation, and those assigned to the accelerated TE program.

The three variables were not statistically independent. Although persistence and placement were uncorrelated, performance

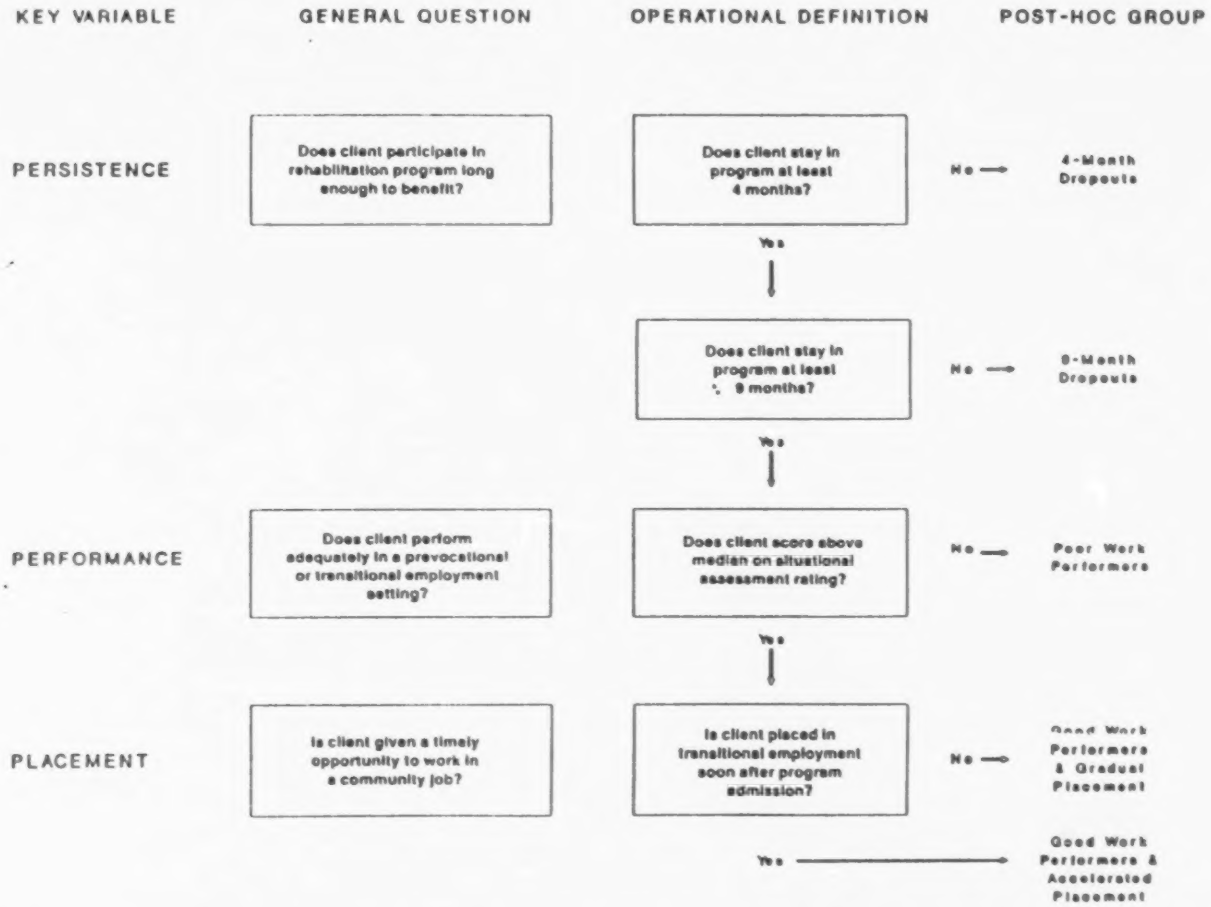
KEY VARIABLE
GENERAL QUESTION
OPERATIONAL DEFINITION
POST-HOC GROUP
PERSISTENCE
Does client participate in rehabilitation program long enough to benefit?
Does client stay in program at least 4 months?
No
4-Month Dropouts
Yes
Does client stay in program at least 9 months?
No
9-Month Dropouts
Yes
PERFORMANCE
Does client perform adequately in a prevocational or transitional employment setting?
Does client score above median on situational assessment rating?
No
Poor Work Performers
Yes
PLACEMENT
Is client given a timely opportunity to work in a community job?
Is client placed in transitional employment soon after program admission?
No
Good Work Performers & Gradual Placement
Yes
Good Work Performers & Accelerated Placement

Figure 11.2. Three conditions for employment success among persons with serious mental illness.

was related to both persistence and placement. Dropout status was correlated with poorer performance on the situational assessment ($r\ (82) = -.26,\ p < .01$). More surprising was the finding that accelerated clients had higher assessment ratings than did gradual clients ($t\ (75) = 2.00, p < .05$).

Persistence appeared to be a critical precondition for successful rehabilitation. As seen in Table 11.6, dropout status identified two subgroups of unsuccessful clients. It is logical to ask further if any client characteristics predict dropout status. In the current study, however, the only predictor variable listed in Table 11.5 that was correlated with dropout status was educational level ($r = -.27,\ p < .001$). More educated clients were less likely to drop out.

Performance in the vocational domain (as measured by the situational assessment) is a second condition for employment success. In the current study, various global indicators of role functioning, including a rating of global functioning and client's self-assessments, were not predictive of outcomes. In contrast, those who received low ratings on the situational assessment had poor vocational outcomes regardless of their accelerated or gradual vocational programs assignment.

Months employed prior to study admission was the only client background variable among those listed in Table 11.5 that was correlated with situational assessment ratings ($r = .19,\ p < .05$). Thus, client background information yielded little predictive information on a client's actual work performance.

Placement was also important for enhancing employment outcomes. Among the subgroup of clients who demonstrated adequate work performance, those in the accelerated TE program were compared to clients in the standard (gradual) program. Accelerated clients had better vocational outcomes than gradual clients: over twice as many accelerated clients were competitively employed and had worked significantly more weeks.

Discussion of the Accelerated Placement Study

From the standpoint of program planning, the findings from the preceding analysis are cause for optimism. The identified factors are all within the control of rehabilitation programs, at least in principle, as discussed below.

Persistence

Several studies have shown that clients who persist, that is, clients who attend PSR programs for an extended period, have the best employment outcomes (Barry, 1982; Bond, 1984; Dincin & Kaberon, 1979; Malamud & McCrory, 1988; Rehab Brief, 1986). Persistence is typically a characteristic attributed to clients and not to programs. However, assertive outreach can increase client participation in rehabilitation (Stein & Test, 1980). No research has yet directly tested the viability of assertive outreach as a means to increase attendance in vocational programs.

Assuming that assertive outreach does increase persistence among clients who otherwise would drop out, a second question is whether reluctant clients so encouraged will benefit from vocational rehabilitation. SE proponents have advanced an idealistic "zero exclusion model," which states that all clients are assumed candidates for employment until proven otherwise (Wehman, 1988). Although this study was not designed to evaluate a zero reject model, its findings can be reexamined in terms of this perspective. Specifically, we examined the outcomes for the subgroup of 30 clients who persisted beyond 9 months but who performed poorly on the situational assessment (see Table 11.6). This subgroup would be viewed by the VR system as poor employment risks. Consistent with that view, they did not have any better vocational outcomes than did program dropouts. Thus, persistence alone provides no guarantee of success in competitive employment.

Table 11.6. Employment Outcomes for the Five Subgroups Identified in Figure 11.2

			EMPLOYMENT STATUS AT 15 MONTHS					
						CREWS		
CLIENT SUBGROUP	WEEKS WORKED[a]	EARNINGS[b]	COMPETITIVE EMPLOYMENT	INDIVIDUAL TRANSITIONAL EMPLOYMENT	GROUP TRANSITIONAL EMPLOYMENT	PREVOCATIONAL	UNEMPLOYED	UNKNOWN
A: 4-month dropouts (N = 19)	5.2	$559	0%	0%	0%	5%	53%	42%
B: 9-month dropouts (N = 35)	10.0	$913	3%	0%	0%	11%	60%	26%
C: Poor work performance (N = 30)	16.1	$731	3%	0%	13%	53%	23%	7%
D: Good performance and gradual preparation (N = 21)	23.1	$1625	14%	19%	19%	33%	5%	10%
E: Good performance and accelerated placement (N = 26)	39.7	$2140	39%	19%	15%	15%	12%	0%

[a] According to the Newman-Keuls test for post hoc comparisons, the following subgroups differ at $p < .05$: A,B < D,E; C,D < E.

[b] According to the Newman-Keuls test for post hoc comparisons, the following subgroups differ at $p < .05$: A,B,C < E.

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Clients who do become engaged in rehabilitation but who have limited vocational skills represent a large and important segment of the total population of persons with serious mental illness. Finding appropriate vocational options for this subgroup remains a vexing problem. At a commonsense level, it appears that some form of systematic skills training may be necessary for these clients to achieve employment success.

Performance

The priority of current vocational performance over work history is an affirmation of the Fountain House principle that every consumer deserves a chance to work, regardless of past problems (Beard et al., 1982). The intent of prevocational and TE programs is to improve client work habits and attitudes. We have surprisingly little literature to show that a client's work performance and attitudes in psychosocial rehabilitation settings does improve over time (Growick, 1976). It would be relatively easy to determine whether situational assessment ratings in PSR programs typically show a steady progression, or whether, as is more likely, a nonlinear path to improvement is more common.

Clients working on the prevocational crews had lower situational assessment ratings than did those on TE. Possibly clients in the prevocational crews felt that little was expected of them, as suggested by frequent reference to poor attendance on their rating forms (Bond & Friedmeyer, 1987). The monetary incentive in TE also may have made a difference in performance (Lehrer & Lanoil, 1977).

A further speculation is that the TE job coaches gave higher ratings because they expected more of their clients in an integrated setting. This possible explanation is reminiscent of the finding from educational studies in which teachers' expectations have been experimentally demonstrated to affect student performance (Rosenthal & Jacobson, 1968). In a similar vein, Kiernan and Brinkman (1988) have also noted an interaction between work performance and the work site. One implication is that community-based assessments may be more ecologically valid indicators of a client's potential than are those obtained in artificial settings (Menchetti & Rusch, 1988).

From a programmatic standpoint, it would seem logical to provide skills training in order to improve client performance in prevocational and transitional work settings. The efficacy of skills training has been examined in over 50 studies (Anthony, Cohen, & Cohen, 1984; Liberman, 1988), yet most PSR proponents have adamantly maintained that an experiential learning approach is superior to more structured approaches. In any case, research has not yet closed the causal chain that hypothesizes that clients can be taught vocational skills and thereby achieve success in community employment.

Placement

The provision of job opportunities is a simplistic addition to the rehabilitation model, yet one that has not been fully appreciated. A study using a similar research paradigm but with individual supported employment placements as the accelerated condition is now in progress (Bond, 1990b). Early anecdotal evidence makes it clear that many clients clearly *prefer* early placement over gradual work preparation *including group TE programs* in CMHCs. This unexpected pattern suggests a strong client aversion to prevocational training programs that are considered progressive in many CMHCs. It is reminiscent of recent survey findings on supported and transitional housing: Most clients prefer to live in their own apartments with adequate support from professionals, despite the opinion of most professionals who think the majority of clients need structured group homes (Blanch, Carling, & Ridgway, 1988).

SUMMARY

Like Dickens' *Christmas Carol*, we have examined the past, present, and possible future of vocational programs for persons with severe mental illness.

The limitations of sheltered approaches for most clients with psychiatric disabilities have been widely documented. Although it is customary to note that sheltered alternatives are appropriate for some clients, to operationalize this assumption has proved difficult. Too often the belief that some clients are more suited to sheltered settings has been used to justify wholesale exclusion of clients from competitive employment. Clients themselves are often reluctant to enter vocational programs. Clients who have self-defeating attitudes perhaps are influenced by rehabilitation workers who believe that psychiatric disabilities are a barrier to employment (Bingham, 1988).

The opposite viewpoint, that clients simply need an opportunity in competitive employment, with supports, is also an insufficient formulation. In the accelerated placement study (Bond & Dincin, 1986), for example, there was a subgroup of clients who did not succeed in TE, even though they attended the rehabilitation program for over a year. Multiple vocational options are necessary to address the spectrum of clients who are admitted to CSP programs.

Although prognostication is a risky business, some observers are predicting expansion of SE services for persons with severe mental illness. A recent comprehensive national survey of SE practices in rehabilitation facilities (NARF, 1989) notes that "individuals with chronic mental illness are receiving more attention nationally" (p. 39), although the survey showed only 11% of the individuals served in surveyed SE programs had chronic mental illness. Another recent survey (Tashjian, Hayward, Stoddard, & Kraus, 1989) showed a large discrepancy between the percentage of clients believed by mental health workers to have access to SE and TE programs (70%) and the percentage of clients actually receiving these services (11%). How much and how fast expansion occurs will depend on many factors, including solving the problems of short-term and long-term funding. SE requires attention to systems issues and financing at the program level, whereas VR has historically funded most of its services on a case-by-case *client* basis. The funding problems are not insurmountable, but they require new thinking.

This chapter has argued that our future includes the incorporation of the *principles* of supported employment. It is already clear that Wehman's provocative model, developed for persons with mental retardation, must be modified considerably for persons with severe mental illness. That adaptation is already being attempted across the United States.

Because current programs with vastly different philosophies have adopted the label of *supported employment*, the term has lost its meaning. In place of labels and slogans, we need empirical benchmarks: Whom does your program admit? What is the dropout rate? What self-selection occurs? What is the average duration in each program phase? What do vocational staff do? What are your employment rates? How long do clients hold jobs? How satisfied are they with the jobs they have?

Supported employment has in no sense been "proven." It conforms with a number of working hypotheses, but has not been examined within a rigorous evaluation framework. Several scenarios for the future of SE for persons with severe mental illness are possible, including the following: (a) SE is implemented only under special conditions, such as in agencies that have charismatic administrators, or in communities where the local VR and MH politics are somehow bypassed. (b) Its evolution is heavily influenced by the characteristics of the local communities and economies. For example, the job bank model may become the dominant model in some large cities, whereas the individualized placement model may evolve in less populated areas. (c) Administrators conclude that SE is not cost effective or that the funding dilemmas are insoluble. In the short term, SE programs appear costly and inefficient. As Wehman (1989) notes, "It usually takes 2 to 3 years for the full benefit and placement outcomes of supported employment to accumulate" (p. 8). Questions about economic feasibility have already surfaced in the Pennsylvania and Indiana projects described above, in which the placement rates were low during the early stages of implementation. In fact, in both states, demonstration sites only first began to make genuine progress during the second year of implementation. In the case of Indiana, the projects were funded for only 2 years, thus severely hampering their development from the outset.

The intent of this chapter has been to generate hypotheses. We are still at an early stage of program description (Brekke, 1988), and better classification of vocational approaches will need to be developed in the future. Some process and outcome variables have been suggested in this chapter that may contribute to a consensus battery of measures that all investigators might use.

Time has been a motif of this chapter. In the past, extensive resources have been directed to prevocational activities, with little demonstrable impact. Conversely, few resources have been directed to the post-placement period (Tashjian et al., 1989), resulting in disappointing rates of job retention (Solberg & Raschmann, 1980). It is time to reverse these priorities.

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Creating Positive Vocational Outcomes for People with Severe Mental Illness

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Abstract: This article is meant to serve as a practical guide to the various vocational alternatives currently in use in the psychiatric rehabilitation field. It presents both benefits and drawbacks to the service recipient, of each of the models described. A perspective is offered on some parallel developments in employment services for people with mental illness and those with developmental disabilities. Finally, consideration is given to using links with the public Vocational Rehabilitation system as part of the array of vocational options presented to clients of rehabilitation service organizations.

The topic of creating positive vocational outcomes for people with major psychiatric disabilities has generated much heat, but a great deal less light, over the last 10-15 years. People with severe disabilities are often "at the end of the labor queue [and] need special assistance in overcoming institutional barriers and re-establishing or establishing a lasting labor connection" (Levitan and Taggart, 1982,p. 127). In particular, the rehabilitation field has not proven itself overwhelmingly successful in helping people with severe psychiatric disabilities achieve stable employment at competitive levels (Anthony & Blanch, 1987; Anthony & Jansen, 1984; Bond & Boyer, 1988; Bond & McDonel 1991; Ciardello, 1981; Hirsch, 1989; Levitan & Taggart, 1982; MacDonald-Wilson, et al, 1991). The literature includes unemployment estimates for people with serious mental illness as high as 80%(Anthony & Blanch, 1987; Tessler & Goldman, 1982; Wasylenki, et al, 1985.) The most recent figures available from the Rehabilitation Services Administration on the performance of the VR system nationwide, for fiscal year 1990, shows a successful rehabilitation rate of VR clients with "Psychotic Disorders" of 48%, compared with successful closure rates for all disability groups of 60-65% (Rehabilitation Services Administration, 1991).

A variety of vocational rehabilitation approaches have been developed in recent years that appear to show promise. These include: the psychosocial rehabilitation approach, perhaps best exemplified by the Fountain House clubhouse model and its attendant Transitional Employment (TE) programming; the psychiatric rehabilitation movement, as popularized through the Boston University Center for Psychiatric Rehabilitation; the

Community Support movement, perhaps best exemplified through the Assertive Community Treatment model developed in Madison, Wisconsin; the Fairweather Lodge movement as demonstrated through the creation of Community Lodges throughout the United States; and the Supported Employment methodology which has "grown up" politically out of the Developmental Disabilities field, primarily through the University of Oregon & Virginia Commonwealth University (Bond & Boyer, 1988; Bond & McDonel, 1991; Cook & Engstrom, 1985; Fairweather, 1980; MacDonald-Wilson, et al, 1991; Malamud & McCrory, 1988; Russert & Frey, 1991; Vorspan 1989). However, the specific capacity of the panoply of vocational placement models developed over the years, to positively affect vocational outcomes is still, in many respects, unproven (Bond, 1990; Bond & Friedmayer, 1987; MacDonald-Wilson, et al, 1991).

Clearly, there continues to be a paucity of "hard" data to justify the use of any one option over another to produce enduring vocational success in community-based psychiatric rehabilitation. Indeed, one of the reasons for this dearth of information is that there is no clearly accepted definition of vocational success , which is used consistently, either in research or program evaluation activities (Bond, 1990). However, the public/private service delivery system faces the immediate need to assist individuals with severe psychiatric disability to (re)enter the workforce of their local communities. They do not have the luxury of waiting until all the research issues are resolved. Service providers usually need to establish and update the research and data base as they help people through service delivery.

It is the intent of this article to provide an overview, for the interested practitioner, client, family member or advocate, of the "pro's and con's" of major community rehabilitation models which pertain to vocational outcomes for people with serious mental illness. The goal is not to provide a substantive research review. Several of the sources cited above, particularly those developed by Bond and colleagues, do an excellent job in this area. Rather, the following analysis is meant to serve as a practical guide to considerations in developing and using the approaches described. When research data are available, this is identified. In most instances, however, what are noted are administrative/clinical indicators for use in setting up and referring people to programs. These facts are presented in a form that should give the rehabilitation professional, consumer, and/or advocate, a way of selecting alternatives that best fit the needs of the person for whom the service is intended.

Models of Vocational Programming

Work Units in a Clubhouse Program

Work units in a clubhouse setting are specific work activities set up to get tasks accomplished which the clubhouse needs to get done. In many ways, work units form the centerpiece of the clubhouse approach to rehabilitation with people with long term mental illness (Vorspan, 1989). This pattern of service delivery based on staff-member side-by-side functioning is commonly referred to as the "work-ordered day". Work units are meant as vehicles for members & staff to work productively together. One of the tenets of clubhouse administration is that staffing should always be such that the work of the club could not be accomplished without the active contribution of the members as well as the staff (Beard, et al, 1982.) In some respects, this structure was developed as a counterpoint to the view, prevalent in the 1950s, of psychiatric treatment as psycho-dynamic "talk" therapy. It emphasizes the value of "productivity," (Whitehead & Marrone, 1986) so essential to the rehabilitation philosophy, while, less consciously, using the concept of developing a person's capacity to nurture and support others as a way of enhancing self esteem.

The traditional types of work units that exist in clubhouse programs are kitchen/cafe, janitorial/housekeeping, clerical (attendance, record-keeping, and fiscal), and public relations (newsletter, tours, public speaking). Sometimes units are created to do maintenance/repair functions, ommunity volunteer activities, fund-raising, and odd jobs in the ommunity.

The "essential" purpose of work units in a clubhouse setting is to benefit the consumer through his/her contributions to keeping the club functioning. Work units are not:

- Volunteer work (any more than cooking for your family is)
- Specific skills training (any more than cooking meals at home helps you learn to run a restaurant)
- A means of assessing or achieving "generic" work adjustment, a vaguely defined concept that, some have argued, doesn't fit the realities of behavior (Anthony & Jansen, 1984).

Except in large programs, specific assignment to a work unit is not crucial. Someone may spend part of a day or a week in one unit, then move on a regular schedule to other units. Some programs may use a members' meeting each day to divide the tasks of the units. Consumer choice needs to be at the core of the process, though methods, such as direct suggestion and use of peer pressure, are often used. Clinically, the method of unit ignation is irrelevant. However, it creates an administrative problem if f cannot count on certain duties getting done each day (e.g., if no one volunteers to cook lunch one day, what will be eaten?)

Transitional Employment (TE)

Transitional Employment (TE) is also a core component of a pure clubhouse model (Malamud & McCrory, 1988). However, many programs that call themselves "clubhouse programs" do not include TE in their service mix—because they do not see it as crucial, they cannot find jobs for their members, or they can't find a way to fund it. A "purist" view of the clubhouse approach would insist that the absence of a TE component is antithetical to its value base analogous to calling oneself a behaviorist while focusing solely on client affect in counseling. Since the development of the TE concept (in the mid-1960s at Fountain House in New York City,) several variations have been developed. In many ways, the TE concept used some of the same principles that were later popularized in the Supported Employment (SE) movement of the 1980s in the Developmental Disabilities field (Bond, 1987). Because of the increased emphasis on the employment aspect of community integration, free-standing TE programs, have become increasingly popular over the last 5 or more years.

TE, in its Fountain House roots, grew out of the intuitive sense that "in vivo" learning was a good way for people to acquire good work habits, as well as out of the belief that members-- by virtue of their skill deficits, lack of a good work history, and status as ex-mental patients-- would almost always have great difficulty in securing employment (Beard, et al, 1982.) In addition, it was assumed that people with major mental illness needed a chance to practice work skills in a setting more "practical" than a clubhouse environment, while less demanding than a typical full time job. The major components are:

1) The responsibility for job development lies in the program, not the individual client.
2) The program accepts the responsibility of recruiting, hiring, & training members for each job. Thus program staff go out & learn the job first and teach the client individually (similar to a "job coach" in Supported Employment).
3) The employer gives up the option of screening the client out via the interview process.
4) The employer agrees to pay workers directly, not through the program, and at least minimum wage.
5) Most full-time jobs are broken up into two part-time jobs.
6) There are time limits on individual consumer tenure in each TE job (usually 6 months). In the "pure" clubhouse model, consumers may switch TE jobs in 4-8 months, but stay in the TE program. In recent years, funding restrictions have led some programs to limit consumers to one TE experience. Thus, the

sense that gets created- that consumers should be able to work competitively unsupported, after one TE experience- is a major bastardization of the concept.

7) The program, not specific clients, are seen as "owning" the job.
8) Because of the above characteristics, the great majority of TE jobs are entry level, experience high turnover, quick training, minimum wage and provide no benefits (by extension, boring & low status).
9) The agency establishes a regular support mechanism away from the job, usually in the form of a weekly or bi-weekly dinner meeting, to enable fellow TE workers to "compare notes" and often to allow potential TE workers to hear about the experience first hand.

Originally, it was not viewed as important to provide TE in an area of vocational interest to a consumer , because the point was to learn about work, not acquire specific work skills. However, the confluence of heightened consumer clout, more people spending greater amounts of time in the community, advances in treatment, use of supported employment approaches, and an increased awareness of the importance of values/interests in skill acquisition has moderated this view somewhat. Unfortunately, the practical realities of the kinds of jobs employers are willing to make available as part of TE (i.e., easy to train, entry level) preclude a really extended range of vocational options. For the foreseeable future, these are usually limited to food service, janitorial, groundskeeping, messenger, and entry level clerical jobs.

While remaining aware of the dangers of generalizing, TE usually is most appropriate for people without much work experience, or who haven't worked in more than two years, or who are unsure whether paid work is an option they wish to pursue. Other considerations concerning TE, which are not value-based, but rooted in the realities of service delivery are that it:

- works best in an urban or suburban setting as opposed to rural areas;
- is fueled better by a service-driven, rather than a manufacturing economy;
- requires jobs which can be taught fairly quickly; and
- requires a steady flow of new clients & new jobs, if a program is willing to provide multiple TE opportunities to its clientele.

The major advantages of a TE approach, particularly vis-a-vis supported employment, include the following:

1) It provides a sense of "graduation" & completion to the worker, often the first successful adult experience in his/her memory.
2) For the worker who is having trouble, the time-limited nature of the experience allows for a sense of "light at the end of the tunnel." For the worker who "fails," having to quit or be replaced, the finiteness of the program enables one to think through the experience as having made it one sixth, one fourth, one third, etc. the way through.
3) In the author's experience, employers often need more education about the TE concept, since it is different from the typical employment endeavor. Once convinced, they are much more willing to take risks and tolerate a consumer with poor job skills. This appears to be due to the fact that the program has established its "ownership," thus its responsibility for the job; and probably most comfortably for the employer, [s]he will not get "stuck" with a poor performer as a natural cycling out process occurs.
4) Because TEs are usually part-time, each job can serve two people at a time and four people a year.

Some of the deficits associated with TE are the following:

1) By definition, the work experiences are transitional. For people with major mental illness, transitions in relationships and in settings, often pose great difficulty. Each transition, even if it is to a similar job, requires increased supports available for the consumer.
2) Skills in one environment do not translate well to a different environment (Anthony & Jansen, 1984; Anthony & Farkas, 1982; Forsyth & Fairweather, 1961). So transferring the skills learned (social, life adaptive, or job specific) on one TE to a different TE, or an independent competitive job, is not often easily done.
3) TEs are not usually developed for "white collar" situations. Convincing a potential worker to see this routine, low status position as a stepping stone, not a dead end, can be difficult. It requires the provider's taking on the responsibility of demonstrating "good faith," through words and action, and creating an expectancy of success in its consumers.
4) Also, as noted previously, if the provider offers multiple TE

opportunities, these need to be in an economic environment that can support this endeavor. Competent marketing staff also need to be available. There is conflict among TE providers about whether to have specific TE job development staff (most common & often more efficient) or insist, in the case of clubhouse providers of TE, that all staff participate in development and on-the-job support activities. The rationale for the latter approach is to try to ensure that TE is seen as an integral, not a tangential, program component, and to maintain the intense support relationship developed between staff & member in the club setting.

Volunteer Work Experiences

Volunteer (i.e., unpaid) work experience options occupy a controversial niche in the array of vocational opportunities for people with long term mental illness. These, more than any of the other concepts covered, vary greatly in their utility, based on the match between individual consumer's needs and the specific form the volunteer work experience takes. The major dispute centers around whether it devalues a person to work without pay as a condition of his/her rehabilitation. In addition, the issue of whether an unpaid (or piece rate paid) worker is being exploited by an employer is of great concern, not only to rehabilitation providers, but, probably more ominously, to the U.S. Department of Labor.

Questions to examine when deciding whether volunteer work is viable a particular situation are:

1) Does the position meet the requirements of the Fair Labor Standards Act, administered through the Wage and Hour Division of the U.S. Department of Labor?
2) Is this part of a formal volunteer program (e.g., something set up through hospitals, schools, non-profit agencies, etc.) or the Federal Unpaid Work Experience Program (Section 501 of the Rehabilitation Act of 1973, as amended)?
3) Are other people being paid to do the same tasks as the volunteer?
4) Is the "employer" making money from the volunteer worker's labor?
5) How will this role affect the ego of the consumer? People beyond teenage or early 20s, particularly those with work experience, are usually not best served through volunteer options. Unless that is the work role they prefer, for financial and/or personal considerations. Or, they are seeking re-entry to

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a professional level environment, in which they can currently not compete, due to their psychiatric illness. Others may find that it leads to diminished self-esteem.

6) If the goal is to move towards paid work experience, does the program have tight, short-term time limits set? This is especially salient to those situations where the aim is to "convert" the volunteer job into a paying one, as a conflict of interest potential is created. Where volunteer work is an interim strategy, limits should be set on the order of 120 hours maximum.

The benefits of using Volunteer Work Experiences, assuming the above questions have been taken into account, are:

1) This approach increases the range of job (task) options for people to try, beyond the usual array of TE and SE settings. In the case of someone who has had professional level ("white collar") or skilled trade experience, volunteering may be a way to try out a similar (or slightly diminished) role, e.g., a lawyer volunteering at a public interest firm, either in that capacity or as a paralegal.
2) For people who lack stamina, or just wish to commit less time to work, there usually is much more flexibility in tailoring volunteer opportunities to a person's preferred schedule than would normally be available in paid work.
3) Many people with mental illness, to avoid the stigma associated with this label, do not wish to be part of a formal "program" (such as TE) which identifies them as consumers of psychiatric rehabilitation services. Engagement in a volunteer option, such as previously mentioned (schools, hospitals, community agencies, etc.), usually allows people to retain their anonymity in this regard.
4) Volunteering in a "traditional" capacity (i.e., social service, health, education), gives people who often have been "patients" and "dependents" most of their lives, a chance to nurture and take care of others. Also, people who do volunteer work, often garner gratitude and accolades for helping, which many consumers of services do not usually receive.
5) For people concerned about the impact of earnings on their public benefits, the unpaid nature of volunteer work may be a bonus, not a detriment.

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As with all the options to be considered, there are several negatives that this approach poses:

1) For people concerned with the need for more immediate income, or who equate income with their personal worth, the unpaid nature of volunteer work is a hindrance.
2) There is a paucity of formal structure associated with most volunteer settings. When the person needs a structured work activity, this option may not be suitable.
3) When volunteer work is used because the consumer does not wish to be identified as a service recipient, the capacity to provide accurate feedback to the consumer on his/her functioning in that role, or support and assistance to work supervisors or other site personnel, is greatly diminished. The program staff are almost totally dependent on client self report for evaluative data. This can obviously be problematic in instances, as often happens, where the consumer's judgment is impaired by his/her psychiatric illness.
4) As previously noted, the U.S. Dept. of Labor requires that workers be paid for work performed, except under very restricted conditions. There is usually no problem with volunteering in a public or non-profit organization, although the same rules govern the behavior of these organizations. However, unpaid positions in for-profit organizations are not allowable, even for purposes of short-term training prior to job placement.

Work Crews

Work crews are not really a discrete service alternative, rather they are a structural technique used to deliver a variety of employment opportunities to consumers. For the purposes of this article, the term "work crew" will be used to refer to any group employment activity used by a rehabilitation program. Distinctions among options will be made in the descriptions rendered in the text.

Typical work crew methodologies are: Group TE or SE, Enclaves, Sub-Contracts in Industry, Affirmative Industries, Client-Employing Businesses, and "Handyman" work crews. There is often much overlap in the terminology. The purpose of the definitions below are to identify the terms typically used in the field. Practical short definitions of each are:

Group TE or SE— Any approach that meets the definition of SE and/or TE, which uses a group, as opposed to individual employment opportunities.

Enclaves— A formal name popularized in the SE literature, "in its broadest application, ... a group of individuals with disabilities who are trained and supervised among non- handicapped workers in an industry or business." (Mank, Rhodes, & Bellamy, 1986, p.143.) This term describes a group of SE workers in one location who usually do one definable task on a work site, but usually in a segregated fashion- either in a separate room or in a specific, separate space in the larger work environment. However, the term has also been applied to a group of SE workers who may be disbursed throughout the work force individually, or in smaller groups.

Sub-Contracts in Industry—A method that a facility based program often uses to fund an "enclave," where the facility contracts for work done at the business location, pays the workers out of the contract, and includes costs of running the facility operation.

Affirmative Industries—A business entity set up for the purpose of employing people with disabilities, usually subsidized heavily by rehabilitation or social service monies. In the earlier SE literature, it was defined as the "Benchwork Model"—where contract work is procured by a service agency (initially, electronics,) and the disabled clientele is paid at piece rate (Mank, et al, 1986) This notion has been expanded more recently to include other, more community-based businesses, such as janitorial services, garden shops, restaurants, etc.

Client-Employing Business—A similar idea to "Affirmative Industries," except that the business here usually employs non-disabled workers as well and may formally embrace the profit motive, rather than providing "vocational services" to clients. Examples of this model which exist in several locations are specialty food operations (e.g., bakeries, cafes) and plant stores/ greenhouses. There are many similarities to the Affirmative Industries concept, except for the mix of workers desired and the possibility of profitable endeavors. However, most programs that fit the mold of Client Employing Businesses have major difficulty in profit generation (Kirzner, 1990.)

"*Handyman Work Crews*"—A "catch-all" concept, coined here, which describes a variety of group options often used by clubhouses or other day programs, that essentially get groups together for day labor-such as house repairs, yard work, agricultural labor, etc. This may form an on-going business enterprise or may be organized on a job specific basis.

The major strengths of the Work Crew approach are as follows:

1) The peer group created can act as a major source of support for the worker. Since developing new relationships is often difficult for people with serious mental illness, the possibility of trying out a stressful rehabilitation event, i.e., a job, without the added stress of forming a new set of relationships can mitigate the difficulties inherent in new learning (McCrory, 1988.) Obviously, the strength of group support is derived from the existence of previously formed bonds. So the mere existence of a group is not necessarily supportive, unless it consists of people already known and liked by the new worker, e.g., other members of a clubhouse program.
2) The presence of a peer group can also act as an effective stimulus to improved performance, by role modeling, peer pressure, and creating a sense of "there's hope for me" in the worker.
3) A work crew is an ideal vehicle to give the most problematic worker a chance to succeed. The group can be used to "hide" a person who does not function at a level normally tolerated by employers in an individual placement.
4) The creation of a work crew on the "handyman" model enables a program to achieve a greater degree of flexibility in its response to generating economic opportunities in the community. In addition, for some consumers, the more flexible time demands and variety of tasks available can be a bonus.

The major deficits associated with Work Crews are as follows:

1) This form of vocational functioning is hard to replicate in the competitive labor market. Thus, as with any transitional approach, the skills learned may not be easily generalized. The nurturance provided by the peer group may be missed sorely by the worker in more traditional employment models, hence making this transition even more difficult.
2) Any group approach, by definition, increases dramatically the segregation of the person with mental illness from the community at large. The problem is more pronounced by options such as sub-contracts in industry, affirmative industries, and some enclaves, than it normally would be with a client-employing business or many "handyman" operations. In the latter two options, there is often more opportunity for contact with non-handicapped co-workers or the public at large. There is a real danger that by relying solely on any work crew opportunity, the capacity of both the worker, and the

community, to interact effectively may be diminished.

3) Poor earnings often go hand-in-hand with many work crew operations. Because it is seen as a good way to get people with more significant disabilities working, often earnings are handled at sub- minimum wage levels, through either production rates (usually in enclaves or sub -contracts in industry) or pooled earnings ("handyman" work crews or Fairweather Community Lodge businesses).
4) Particularly for the "handyman" crew and some sub-contract methods, the work offered can be erratic, seasonal, and unpredictable. To a lesser extent, this problem also occurs in the business models where activity, and income, are dependent on customers using a service. Having workers and staff available to meet market needs can be quite problematic- especially, for smaller rehabilitation programs and/or poorly marketed services.

The usual types of Work Crew job opportunities are in the areas of catering, cleaning, household help, shopping services, yard work, house repairs, horticultural, agricultural labor, bakeries/cafes/ diners, and particularly for sub-contracts in industry/enclaves- manufacturing companies. The "handyman work crews" are better suited to rural, than urban environs. As noted, the sub-contract approach works better in an industrial economy, as opposed to a service-based economy. The small business endeavors (either Affirmative Industries or Client- Employing Business) are better suited to an urban/suburban service based economy.

Supported Employment

Supported Employment has come to be identified with day programming for individuals with developmental disabilities. Only after its initial phase, from 1978-1986, was this concept seen as being useful for individuals with mental illness. The reality is, however, that the clinical concepts inherent in this approach to rehabilitation service delivery: "in vivo" learning, i.e., site-based training, on- site support, zero reject policy, i.e., a presumption of suitability, and work integration(Minnesota DHS/Dept. of Jobs & Training, 1989) were not solely derived from work in the field of developmental disabilities.

These have been cornerstones of the psychiatric rehabilitation movement at least as far back as the mid-1960s (as evidenced by the Lodge models and psychosocial rehabilitation clubhouses such as Fountain House.) What Supported Employment has done, as exemplified by the passage of the Title VIC legislation in 1986, which amended the Rehabilitation Act of 1973 and the award of "Systems' Change Grants" to

39 states over the last six years, has been to transcend the concept of employment services from a strictly clinical issue- which it had been seen as, in its genesis in psychosocial rehabilitation. Rather, the proponents of SE in the developmental disabilities arena, transformed the debate to one of Civil Rights and societal inclusion, not simply one about the best ways to deliver services. Also, SE was much more of a radical departure from the norm of developmental disability day programs. These programs often were designed on a Special Education model, because day programs serving persons with developmental Disabilities were an outgrowth of school and institution based services developed by special educators. On the other hand, day programs for people with mental illness, were usually developed on a medical, not a rehabilitation model, and were usually created by adult service providers.

The core components of SE, as defined through the Federal Rehabilitation Amendments of 1986, with subsequent regulatory revisions in 1992, are that it consists of:

1) *Competitive Work*—done weekly, being done for pay, though not necessarily at minimum wage or above (consistent with the Fair Labor Standards Act).
2) *Integrated Work Setting*—ideally consisting of individual placements, but in no case forming groups of more than eight workers. Also, it must include regular contact with non-disabled people, other than caregivers.
3) *On-Going Support*—must include at least twice monthly support (formerly required on-site skills training, except for people with mental illness, but are more flexible in the most recent regulations).

An important adjunct to these components is the fact that for the purpose of this legislation, TE for persons with long-term mental illness is considered an acceptable SE outcome, as long as there is an organizational commitment to continue to assist the individual through a succession of TE placements and/or into competitive employment (State Supported Employment Services Program Regulations, 1992).

The major advantages and disadvantages to SE as a service strategy for people with mental illness are in most ways similar to those with TE, with the obvious exception that SE is designed for the person to remain on the job as long as [s]he wishes and is able to. So, the pro's and con's of "transition" and "time-limitedness" play out differently for each strategy.

Traditionally, SE and TE providers have assumed that since mental illness is not an intellectual deficit, there was very little need to concentrate on systematic training methodology. However, more attention should be devoted to insuring that job training matches individual learning styles. Difficulty in skill acquisition can be a source of added stress on a client, particularly in one who lacks a history of success and self-confidence- the great majority of the consumers with major mental illness. Many times, a person who is having typical new job "problems" (e.g., forgetting co-workers' names after introductions), internalizes this adjustment problem into something much worse (e.g., "I must be having trouble concentrating. Does this mean I'm getting sick again?") Job instruction can quickly resolve many such problems.

Fairweather Community Lodge

The Fairweather Lodge (now often called the Community Lodge) model grew out of research developed by George Fairweather, Ph.D. in the late 1950s in Palo Alto, California. It's fundamental premise was that "groups have a powerful influence on their members and can serve as a means to control deviancy and/or psychopathology" (Fairweather, Sanders, Cressler, Maynard, 1969, p.1). From this premise, a set of core principles evolved:

- The social system people inhabit is a better predictor of behavior than individual personality variables;
- People can learn skills needed to function in a group and reach effective group decisions by consensus;
- People in a Community Lodge need to establish a group small business enterprise as a way to maintain themselves as a cohesive group within the community,
- Residents of a Community Lodge need autonomy on group decision making.
- Mechanisms need to be established in a Lodge for continuous information feedback on performance back to the residents.(Tornatzky, et al, 1978.)

With the lack of a large, long-term in-patient hospital population, the Lodge concepts have had to be adapted to people with mental illness starting from a community reference. These principles have been embodied into a model which involves groups of 5-10 people with mental illness living together in the community, operating a group-owned business. Members write the rules for the Lodge and the business. Businesses can allow Lodge residents who have moved out of the residence to sometimes remain employed by the business, with the consensus of the group members (Fergus, et al, 1991). Even though not in the original design, many states that use the Lodge model incorporate it into their more traditional residential continuum, such as halfway houses or Adult Foster Care.

The positive and negative features of this vocational model incorporate many of the same elements noted previously in discussing other group approaches to work. However, the unique nature of several Lodge concepts create some special characteristics which are noted below.

Some positive features, particularly associated with the vocational piece of Community Lodge implementation are:

1) Members have usually been formally taught group functioning and consensus building skills as part of the comprehensive Lodge program.
2) While all group modalities theoretically carry the advantage of peer support, the Lodge model, with its residential and formal group building component, enhances the capacity of the group to act supportively towards all its members.
3) There is a personal "stake" in the work piece because it flows directly from membership in the Lodge group. In some respects, the Lodge business is similar to work units in a psychosocial clubhouse, in that it is not just a job, but a way in which the participant demonstrates- commitment to the entity to which [s]he belongs.

Some negative features, particularly associated with the vocational piece of Community Lodge implementation are:

1) Creating a small business enterprise is a high risk venture for anyone, with the number of failures outweighing successes. This issue is especially germane in light of the fact that Lodge members rarely have a reservoir of successful community business experience on which to draw.
2) Since Lodge residents live and work together, the potential for conflicts and interpersonal dynamics to carry over from one environment to the other is great. The same reasons why people find it difficult to work with relatives or spouses hold true here.
3) Since a core part of the Lodge approach involves decision-making by consensus, the capacity for many Lodge business work groups to act quickly and decisively in response to economic necessity (either by choosing profitable business alternatives, based on market need not just job preference, or reacting to demands of the business flexibly by changing procedures or rules) is often limited.

4) Since the Lodge is usually tied into a human service component (most often, mental health residential services,) there are not necessarily, but often, rules and regulations which can hinder effective "for profit" business (e.g., hours of operation, staffing requirements, house meeting times, location, etc.).

Liaison with Local Vocational Rehabilitation (VR) Agency

An ideal service program would include all the components described in the preceding pages plus a direct, competitive placement component. The realities of scarce resources (financial, skills, energy, staff, etc.), differing philosophies on how to help people, and low incidence need in any specific, geographic area mitigate against this happening in all but a very few, if any, locations. Therefore, most smaller, more restricted programs need to include some liaison with the local VR system as a way of expanding the service mix available to their clientele. For smaller programs with few staff, this linkage may be the major service delivery mechanism in terms of volume of consumers served. The trade-offs for this collaborative approach are that continuity of care is regularly sacrificed and the referring organization (and its clients) are left to negotiate the "appropriate/inappropriate" referral maze.

What many programs ignore, or forget when trying to refer clients to another system, is that they are engaged in a marketing process. Any service system should be driven by responsiveness to client needs, but many variables intrude. It is up to the referring agency, which bears the responsibility for advocating for services for its clientele, to attempt to overcome these barriers. This is not to absolve the "receiving" system of responsibility of making itself more accessible to new clients, but rather is meant to acknowledge the fact of system advocacy as a key role for referrers. Marrone, et al (1984) describe the concepts of "Positive Indicators," "Negative Indicators," and "Red Flags," in examining how VR counselors make the subjective decisions early in the referral process about which clients with mental illness they will accept for service. It is important to note that these decisions are fueled, not by a strict feasibility/predictability factor, as often implied, but rather, by more human factors like comfort level, personal interest in the client or referrer, ease of record access, and perceived client interest in VR services.

First and foremost, as noted previously, the major goal of effective inter-agency referral and collaboration is not good relations among staff. It is access and effective service delivery to consumers. Therefore, a person making a referral for VR services must be willing to "take the heat" that effective advocacy entails. However, an on-going, productive collaborative relationship should reflect both mutual respect and the utilization of marketing principles (i.e., meeting the needs of the "customer". In this case, VR is the recipient of the attention -- i.e., the customer.)

A referral agency that uses these precepts should understand not just VR agency issues, but also the core principles of rehabilitation- such as need to be productive, individual control, focus on the person and the environment, a skills/strength-based model of helping (Kiernan, et al, in press). In addition, if the goal of the relationship is to receive funding, as well as refer clients, it is most probable that the MH program would do so under the rubric of "work adjustment"- which can be a broad, "catch-all" category of service delivery. It is frequently most effective to identify VR outcomes which linking with the psychiatric rehabilitation program can help the VR counselor achieve. Examples of types of outcomes which might prove useful to identify, depending on the nuances of a particular place and time, are:

- Rehabilitation (work) potential leading to a "Status 26" or successful closure;
- Increased applicants or eligible clients;
- Increased "Rehabilitation Rate"—percentage of clients closed successfully of all closures; and
- Reduced failure rate or closed unsuccessfully—"Status 08", "Status 28" or "Status 30."

It is crucial to note here that an effective marketing approach on the part of the mental health program requires an understanding of which of these, or other outcomes, the individual VR counselor or office considers desirable in the given circumstance. Essential to this strategy is the development of a personal alliance with a specific VR staff member. People relate to other people, not to systems. In service to this idea, an effective engagement is based on greater frequency of contact, rather than larger amounts of time spent there. Spending one hour a week on a program site is a more useful engagement strategy for a VR counselor than spending one entire day a month. Increased frequency allows for much more personalized and suitably intense relationships, than larger blocks of time, spread out longer.

Conclusion

The author has presented a wide variety of alternatives that practitioners in the community psychiatric rehabilitation field are currently using. No specific model or approach is effective enough with any group of persons with serious mental illness to be used to the exclusion of the others. What the field does know, is that the more traditional ways of treating people with mental illness, such as purely from a clinical mental health frame of reference, does not, in and of itself, help people achieve vocational goals. Even in the vocational sphere, using either a sheltered work model or its polar opposite, "just" getting people jobs without much built in support, does not produce anywhere near acceptable results. Much needs to be done, before advocates for people with mental illness in the vocational arena can tout any one methodology in preference to another.

Each of the alternatives noted has positive features and accompanying flaws. In the practical reality in which most programs and providers operate, no perfect "technology" exists to produce enduring, positive vocational outcomes for people. Technology is an accurate term when there is the capacity to replicate positive results consistently (as when one turns on a light switch, or when a plane takes off.) That capacity does not exist currently, or in the foreseeable future in vocational services.

Any service has to be offered in the context of a caring, hopeful, supportive relationship between the helper and the client (Deegan, 1988; McCrory, 1991). In the absence of such caring and personal commitment, which flows from an emphasis on meeting client desires and needs, none of the approaches cited can be efficacious. With these qualities, in addition to the Herculean efforts clients undertake themselves even to gain access to the services described, any one of these services can be used to achieve vocational benefits on behalf of people with serious mental illness.

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Supported Employment Outcomes for People with Psychiatric Disability

A Comparative Analysis

Participation in paid work in competitive industry through placement in supported employment is compared and analyzed for two populations: 212 persons with a primary psychiatric disability and 1,588 persons with a nonpsychiatric primary disability. Results are organized in two areas: service patterns through an analysis of types of interventions, and outcomes from supported employment services. Results indicate differences in the types and amounts of interventions provided, with the majority of interventions for both populations studied provided at the job site. Persons with a psychiatric disability consistently earn higher wages across a variety of service models than do persons in the other group. Differences between the two populations were also found in types of jobs, job retention, and reasons for separation from employment. Results represent an expansion of the limited data base available to evaluate the design and effectiveness of supported employment services for persons with a psychiatric disability.

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SUPPORTED EMPLOYMENT

Supported employment (SE) is defined as part-time or full-time competitive paid work, averaging at least 20 hours per week in integrated work settings where contact with nondisabled people regularly occurs, and with extended services provided beyond the allotted maximum of 18 months of state vocational rehabilitation sponsored services.[1] It is targeted specifically for persons with severe disabilities for whom competitive employment has been intermittent or has not traditionally occurred. A number of

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federal initiatives in the mid-1980s assisted states nationwide in developing SE opportunities. First, the Rehabilitation Services Administration funded 10 five-year grants in 1985, with an additional 17 grants funded in 1986, to develop state systems of SE.[2] The 1986 Amendments to the Rehabilitation Act implemented the Supported Employment Services Formula Grant program, making federal funds available to all state rehabilitation agencies to provide time-limited SE services.

Initially, SE program models and demonstration efforts were designed primarily to serve persons with mental retardation,[3,4] and later, people with other disabilities. In fiscal year 1988, 16.7% of the persons reported to be in SE positions nationwide had a primary disability classification of mental illness.[5] While there is a trend toward increasing the use of SE services with this population and identifying ways to tailor services for people with psychiatric disability,[6–10] there is little data on the effectiveness of the approach or on actual differences in provision of SE services for people with severe psychiatric disability.

Psychiatric disability is defined as a disability due to psychiatric illness of prolonged duration, which limits one's capacity to perform certain functions (e.g., obtaining a job, interacting with family, etc.) and ability to perform in certain roles (e.g., worker, student.)[11] This definition is drawn from elements common to three often-used definitions: the Rehabilitation Services Administration's (RSA) definition of severe disability; the National Institute of Mental Health's Community Support Program (CSP),[12] and Goldman's definition.[13]

Many people who became disabled from mental illness experience their first episode in adolescence or young adulthood. Psychiatric disability is episodic in nature; that is, people experience cycles of exacerbation and remission of the symptoms of major mental illnesses such as schizophrenia or bipolar disorder. Functional deficits associated with the impairment create workplace problems such as inconsistency in performance and interpersonal relationships.

In spite of a wide range of educational experiences, intelligence, career aspirations, and previous work history, people with severe psychiatric disability typically have unemployment rates as high as 85%–100%.[11] The average unemployment rates for persons with other disabilities is 50%–75%.[14] Literature reviews conducted by Anthony and associates consistently have demonstrated employment rates of 20%–25% for all persons with psychiatric disability discharged from hospitals, but 0–15% employment rates for those considered severely psychiatrically disabled.[15–20]

Vocational rehabilitation programs have demonstrated limited success for people with psychiatric disability. According to the RSA, based upon 1985 general agency data on "rehabilitations," people with mental illness make up the next-to-largest category of disability serviced at 17.8%, but they have the lowest rehabilitation rate of successful closures (employed for a minimum of 60 days) at 56% compared to all other disability groups at 66%.[21,22] Bond and Boyer[23] found that there are no conclusive studies that the psychosocial rehabilitation approach, a program using prevocational work crews and transitional employment (TE), improves competitive employment rates. However, accelerated entry into TE results in a 20% competitive employment rate after 15 months beyond the initial TE placement, especially for those with previous work experience.[24] There is also some data from Fountain House to suggest that the longer one progresses beyond the initial TE experience, the better are the chances of becoming competitively employed.[25] However, these rates are not much higher than the base employment rates for people with severe psychiatric disability.

Preliminary data on SE outcomes for people with psychiatric disability is beginning to appear, but references in the literature are scarce. Most prevalent in the literature are proposed descriptions of needed modifications of SE for people with psychiatric disa- bility.[6–10] Some conclusions can be drawn from these descriptions regarding the modifications of SE for people with psychiatric disability. The following list summarizes some of these major modifications.

- Emphasis on active involvement describing personal job values for job match
- Longer preemployment phase to choose a job
- Wider variety of job types
- Opportunities for advancement
- More time educating employers and co-workers
- Larger proportion of support time offsite during nonwork hours
- Greater proportion of training time in emotional-interpersonal skills
- Intervention hours after placement peak intermittently over time

Some literature is now appearing regarding effectiveness of SE for people with psychiatric disability. In a study by Collignon, Noble, and Toms-Barker[26] on integrating mental health and vocational services in Marin County, California, over 50% of individuals placed sustained part-time and full-time employment with limited follow-up in the first year, usually with the same employer. However, as more severely disabled people entered the program, fewer maintained employment. The study concludes that ending support services may be feasible for only a few people. The services involved competitive employment, SE, and TE, along with other vocational and prevocational services. No information is available on the specific types of intervention, total number of hours of intervention, types of jobs represented, or reasons for separation from the job.

In a description of SE program development in Maryland, Isbister and Donaldson[27] reported that, of 19 individuals placed in SE by the Schapiro Training and Employment Program—S.T.E.P., Inc.—from September 1, 1986, to publication in the fall 1987, 14 remained employed, at an employment rate of 74%. Of the 5 who left their jobs, 1 was hospitalized (5%), 2 chose not to work (15%), and 2 were terminated for inappropriate sexual and aggressive behavior (15%). The types of jobs included caseworkers, gasoline attendants, maids, banking clerks, maintenance workers, secretaries, doughnut makers, and factory workers. Again, there is no information on the amount or pattern of intervention hours, time spent on specific types of intervention, or the distribution of workers across jobs.

Fabian and Wiedefeld[28] updated a study of S.T.E.P., Inc., which is described as an individual-placement model of SE for people with psychiatric disability. After a seven-week intake group meeting of 2 hours per week, 69 clients were placed in jobs. Intervention emphasized training in interpersonal skill development and increasing productivity, systematic fading, and ongoing support, with a weekly 2-hour job-retention group and a job site follow-along service, which is characterized by a series of peaks in intervention time. Results indicated that participants worked a mean number of 27.4 hours per week, earning an average of $4.13 per hour. Forty-seven percent of those employed held their jobs for at least 6 months. Job coaches spent an average of 20 hours per week during the first month. Data is provided on reasons for job separation and types of jobs, but no information is available on intervention patterns or specific allotment of types of intervention hours.

People with psychiatric disability clearly have difficulty in obtaining and sustaining employment. Traditional vocational rehabilitation, psychosocial rehabilitation, and TE services have had limited success in improving competitive employment rates, especially once services end. SE has been effective with people who have other disabilities. This study was undertaken to evaluate the effectiveness of SE for people with psychiatric disabilities. It identifies patterns of SE services by analyzing the types of *interventions* provided by employment specialists, both at and away from the job site. It also analyzes key *outcomes* from SE services in areas such as wages, integration at job site, type of employment, job retention, and reasons for job separation. Service patterns and outcomes for people with psychiatric disabilities are compared to other persons with disabilities.

METHOD

The Employment Data Management System

The Virginia Commonwealth University Rehabilitation Research and Training Center

(VCU-RRTC) on Supported Employment operates a comprehensive management information system designed to monitor the employment outcomes of targeted workers with a severe disability from Virginia. The Supported Employment Information System (SEIS) consists of client employment outcome data generated from approximately 61 local programs throughout Virginia. As of June 1990, the data base contained information on 1,800 persons with disabilities placed in employment.

Overview of the Data Management Process

The SEIS consist of over 200 data elements, organized into 9 data-collection forms. The system provides detailed information on target employees' demographic and functional characteristics, consumer assessment, results of job analyses, comprehensive data on the type of job performed by the employee, amounts and types of services provided by the SE program, and supervisors' evaluations of the target employee's work performance; and it provides complete information regarding employment retention and reasons for job separation. Some data elements are collected one time only; others are collected on regular three- or six-month intervals; and still others are collected on a continuous, daily basis.

Data forms are submitted on a prescribed schedule, and a data-management specialist reviews each form for completeness, accuracy, and consistency with previously submitted data. Data are entered through a remote terminal into an IBM 3081K mainframe computer for analysis. Following data entry and analysis at VCU, summary reports are then returned to state agencies and local SE service programs on a quarterly and monthly basis. All SEIS participants receive aggregated statewide reports that contain both numerical tables and graphic depictions of data. All quarterly reports contain complete information on the immediate quarter, as well as cumulative information, to allow managers to monitor the results and growth of an individual program over time.

Nature of All Persons in Data Base

The 1,800 persons placed into SE that make up the data base have a variety of primary disabilities. The overwhelming majority of individuals (70.7%) are diagnosed as mentally retarded (MR). Of the persons with MR as either a primary or secondary disability, 9.5% are in the severe/profound MR category (IQ < 39; 32.7% are moderate MR (IQ 40–54); 46.3% are mild MR (IQ 55–69); and 11.5% are borderline MR (IQ 70–79). Of the non-MR population, 11.8% are persons identified by service providers as having a primary disability of emotional disorder/chronic mental illness (CMI). The remaining 17.5% are persons with other primary physical disabilities including but not limited to traumatic brain injury or cerebral palsy.

Persons were selected for placement into SE for a variety of reasons, including the availability of a potentially appropriate job match, the availability of transportation and family support, the prioritization of services to certain individuals by funding agencies, and the economic pressures to obtain employment. This study was not experimentally controlled, leading to the potential for subject selection bias by participating programs. Also, the cumulative patterns of data for the non-CMI population, with its dominant MR component, are more clearly established because of their longevity in the SEIS as compared to the CMI population. The data is, however, representative of a large sample of persons served through a statewide system of SE.

Demographic Characteristics of Persons in Present Study

The study that follows is an analysis of data submitted by Virginia Supported Employment Providers on 212 persons in the SEIS data base who are identified as having a primary disability of emotional disorder/CMI. These individuals represent 11.8% of all reported SE participants in the state as of June 30, 1990. The 1,800 persons studied have been placed into work through an SE service provider. Functional and historical information is not available for this study on demographic descriptors such as length or number of hospitalizations or severity of the mental illness for the CMI population. Persons for whom data are submitted to the SEIS in Virginia predominantly are served by the state vocational rehabilitation agency and have substantial handicaps to employment.

Primary demographic information available on the study population involved age at referral, disability classification, receipt of federal disability income benefits, and residential situation. The mean average age of referrals for employment services for the CMI population is 34.5; mean average age for the non-CMI referrals is 28.9. Of the 212 persons with CMI, 16.5% have a reported secondary disability of MR, predominantly at the borderline or mild level. At referral, federal disability income benefits are received by 42.3% of the CMI population and 70.7% of the non-CMI population. At the time of first placement, 33% of the CMI population live independently; 37.7% with family or relatives, and 29.3% in supported or supervised living arrangements. For the non-CMI population, 14.2% live independently; 58.2% with parents or relatives; and 27.6% in supported or supervised living arrangements.

Nature of SE Model

Over 76% of the clients in this study are served in the individual-placement model of SE. This model utilizes an employment specialist as job coach to provide structured job-placement services and highly individual and intensive training at the job site with additional supports provided away from the job site as needed by the individual. The unique feature of SE is that the focus of vocational intervention (e.g., training, counseling, and support) occurs at the job site while the person is employed. Many of the persons now served in SE have previously been unsuccessful in retaining competitive-level work due to (1) their inability to generalize or retain skills and (2) the presence of major social, behavioral, and/or physical problems. An SE specialist provides intervention based on the job requirements and challenges presented by the individual. The employment specialist gradually reduces time at the job site, based on observed work performance improvement and biweekly reports from the business supervisor. Once removed from the actual site, the employment specialist maintains ongoing follow-along with the employer and employee that will continue as long as is needed to assist in maintaining successful employment.

Provider Outcomes

In September 1985, Virginia initiated a formal effort to develop a statewide capacity to provide SE services to persons with severe disabilities regardless of their disability. Initially, a primary population of persons with MR was served because of the availability of service providers and ongoing support funds for this population. As of June 30, 1990, a steadily increasing percentage of persons with CMI was being referred and placed into SE relative to the total population being served.

The VCU-RRTC SEIS contains information on 1,800 persons placed into SE positions in Virginia. Of these 1,800 individuals, 973 are reported working as of June 30, 1990. As indicated in Table 1, 105 (10.85%) of the 973 persons are CMI. In comparison, 15.5% of the referrals for placement and 12.0% of the placements made by Virginia's providers during the April 1, 1990–June 30, 1990 quarter are persons with CMI.

SE services involve a variety of interactions, termed *interventions*, by an employment specialist with the disabled person, the employers and coworkers, the family members, and others. Interventions can occur both on and off the job

Table 1. Profile of Provider Outcomes: Virginia State System as of June 30, 1990

Outcome Measure	Number of Persons with CMI	Number of Non-CMI Persons
Employed	105	868
In referral pool	117	685
Placed in job this quarter	21	150
Referral for placement for this quarter	15	82

site. These interventions are broken into eight categories in the SEIS as follows:

Intervention Time Directly Related to Job-Skills Training

1. Active Time: Time at job site actually spent working with consumer, including active observation. Includes anything done to actively train the consumer.
2. Inactive Time: Time spent on the job site between periods of active intervention. This is time during which you have removed yourself from active involvement with and/or active observation of the consumer.

Intervention Time Indirectly Related to Job-Skills Training

1. Travel/Transport Time: Time used in traveling to a job site, to a meeting about a consumer, or to the consumer's home or in transporting a consumer anywhere.
2. Consumer Training Time: Time spent training the consumer in other than directly related job skills while he/she is not at work. Examples are money handling, grooming, counseling, bus training, family matters, and so on.
3. Consumer Program Development: This is time spent developing appropriate instructional plans (writing task analyses and behavioral intervention programs). Consumer-specific job development is NOT included here.
4. Direct Employment Advocacy Time: Time spent advocating for the consumer with job-site personnel for purposes directly related to employment. These persons would include employers, supervisors, coworkers, and customers. Consumer-specific job development is also included here.
5. Indirect Employment Advocacy Time: Time spent advocating with persons not directly affiliated with the employment site. These persons would include bus drivers, school personnel, landlords, case managers, bank personnel, parents, and so on.
6. Consumer Screening/Evaluation: Time spent screening consumer referrals to determine eligibility for services or evaluating eligible consumers. Any time spent analyzing any information relevant to a consumer's employment potential is included here. The following, when done for purposes of screening or evaluation would be included here: Reviewing consumer records; consumer interview; communication with parents or guardians or involved agencies; observation of consumer in real or simulated work settings.

RESULTS

A presentation of the results comparing the CMI population to the non-CMI population will be organized in two areas. The first area is represented by data concerning interventions by the employment specialist. This area includes intervention categories, total intervention hours, and patterns of interventions. The second area to be presented involves the outcomes of SE. This area includes integration at the job site, hourly wages, type of work obtained by supported employees, job retentions in first placement, and separations from employment.

Intervention Hours by Category

A comparison of the intervention-time categories as described in Table 2 for the CMI and

Table 2. Intervention Hours by Category

Intervention Time Category	Percent of Total Hours: Persons with CMI	Percent of Total Hours: Non-CMI Persons
Active time on job site	31.2%	43.7%
Inactive time on job site	8.5	10.3
Travel and transport time	15.8	15.8
Training time	10.2	3.5
Program development	4.2	5.2
Direct employment advocacy	15.9	11.9
Indirect employment advocacy	9.0	6.6
Screening and evaluation	5.3	3.4

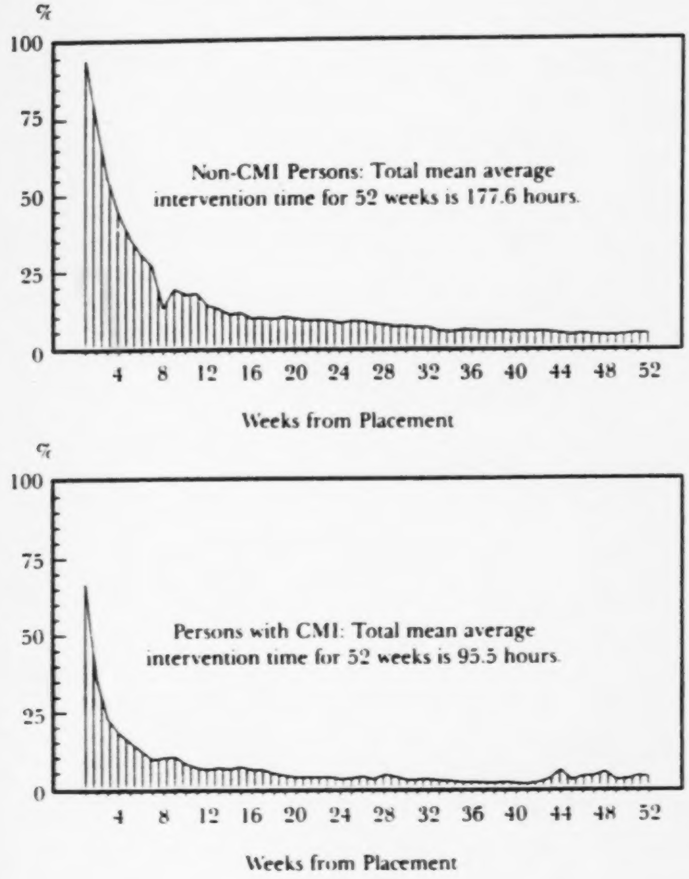

Figure 1. Weekly totals of intervention time as a percentage of consumers' work time reported by Virginia Providers

non-CMI populations indicates three primary areas of differences. Active time on the job site is 31.2% for persons with CMI as compared to 43.7% for the non-CMI population. Given the predominance of persons with MR in the non-CMI population, the 43.7% is representative of the job-skill-training needs of the MR population. In comparison, the CMI population shows a greater need for consumer training, involving training away from the job site, and for direct and indirect employment advocacy than do persons in the non-CMI population.

Figure 1 shows the intervention patterns over a 52-week period. Weekly totals of intervention are represented as a percentage of work time by the supported employees. Mean average total of intervention hours over a 52-week period by employment specialists serving persons with CMI is 95.5 hours as compared to 177.6 hours for the non-CMI population. Figure 1 shows that intervention hours drop below 20% of the hours of employment by approximately the fourth week for the CMI population as compared to approximately the seventh week for the non-CMI population. The intervention hours provided during both the initial training phase and the ongoing support phase of SE are consistently less over a 52-week period for persons with

Table 3. Mean Hourly Wages for Placements In Various SE Programs

Employment Program	Placements of Persons with CMI (N = 253)*	Placements of Non-CMI Persons (N = 2205)*
Mobile work crew	$2.86	$2.75
Enclave	$4.10	$3.14
Supported job	$3.78	$3.49
Supported competitive	$4.50	$4.04

*N for Table 3 is based on number of placements/positions reported. Some individuals in the SEIS have received multiple placements.

Table 4. Type of Work

Job	Person with CMI (Percent of Total)	Non-CMI Persons (Percent of Total)
Food service	25.4%	37.6%
Janitorial/custodial	22.5	26.4
Unskilled labor	1.1	2.1
Bench work/assembly	7.6	6.9
Laundry	0.7	2.8
Stock clerk/warehouse	19.6	10.4
Transportation	4.3	2.1
Clerical/office work	12.7	7.5
Groundskeeping	2.9	2.6
Human services	3.3	1.4

CMI as compared to the non-CMI population. Of note is the series of peaks in intervention hours over time for people with CMI as compared to the fairly consistent level of intervention over the year for the non-CMI population.

SE Outcomes

Level of integration in the workplace. Predominantly, the degree of work-related interaction at the workplace for both populations is moderate and frequent. Eighty-eight percent of the CMI population and 82.8% of the non-CMI population are reported as having moderate-to-frequent interaction. Both populations appear to be employed in jobs with significant integration in the workplace.

Hourly wages for persons in various employment programs. As reported in Table 3, the CMI population has higher hourly wages in all SE program models.

The average hourly wage across all employment programs for the CMI population is $4.39 with a 30-hour average work week ($131.70 in earnings per week). The average hourly wage for the non-CMI population is $3.81 with a 29-hour average work week ($111.65 in earnings per week).

Type of work. Predominant job areas utilized for all persons in the SEIS are food service, janitorial/custodial, stock clerk/warehouse, and clerical/office work. As shown in Table 4, the food-service and janitorial/custodial job areas account for 47.9% of the placements for the CMI population. Persons with CMI make noticeably higher use of stock clerk/warehouse and clerical/office work job areas (32.3% combined than do persons in the non-CMI population (17.9% combined).

During the April–June 1990 quarter, 52.3% of the placements made for the CMI population are in the stock clerk/warehouse and clerical/office work categories as compared to 42.0% of the placements in the food and janitorial service industries. The non-CMI population also demonstrates an increase in the stock and office clerical areas, accounting for 23% of the quarterly placements. Quarterly statistics indicate an increased use of the stock and office clerical areas for all populations and a decrease in the percent of placements in the food- and custodial-service areas.

Job retention in first placement. Job retention is a critical variable in evaluating the effectiveness of SE programming. As indicated in Table 5, the CMI population has a consistently lower percentage of job retention in first placement than does the non-CMI population. Three months after first placement, 66.0% of the CMI population remained in the initial job as compared to 77.5% of the non-CMI population. Eighteen months after first placement, 25.7% of the CMI population remained in the initial job as compared to 42.6% of the non-CMI population.

Table 5. Job Retention in First Placement

Months of Employment in First Placement	Persons with CMI: Percent Retaining Job	Non-CMI Persons: Percent Retaining Job
3	66.0%	77.5%
6	53.0	63.4
9	42.8	55.5
12	36.3	50.6
18	25.7	42.6

SE involves a substantial investment of resources by the funding agencies, particularly during the initial stages of intensive job-site and related interventions to stabilize work performance of the supported employee at a level acceptable to the employer. Job retention and the degree to which the supported employee utilizes multiple placements are therefore significant cost-and-outcome-related issues for funding and service agencies involved in SE. Eighteen months after first placement, 40.3% of the CMI population are employed in their *first or subsequent* placement as compared to 59% of the non-CMI population. Also, 19.3% of the CMI population are discharged from services while still employed within 18 months of their first placement, usually because ongoing support services are no longer needed; for the non-CMI population, 5.6% are discharged from services while still employed within 18 months after their initial placement. Employment histories 18 months after initial placement are available within the SEIS on 109 persons with CMI as compared to 1,023 of the 1,588 individuals in the non-CMI population.

Separations from employment. Reasons for separation from employment fall into two general categories: employer-initiated and employee-initiated. As shown in Table 6, employer-initiated separations (laid off or terminated) occurred with noticeably less frequency for the CMI population (40.6%) than for the non-CMI population (54.6%). Conversely, the CMI population had a higher percentage of employee-initiated separations through resignations (58.6%) than did the non-CMI population (44.0%).

Table 7 shows the large number of specific primary reasons given for separations. For the CMI population, the most frequently cited reasons for separation are not wanting to work, medical health problems, and taking a better job. For the non-CMI population, the most frequently cited reasons for separation are economic situation along with taking a better job and not wanting to work. It is important to note that separations caused by work-related factors such as poor work quality, aberrant or insubordinate behavior, or poor work attitudes are not primary reasons for separations for either population.

DISCUSSION

The results of this study indicate a number of noticeable differences in interventions for persons with CMI as compared to a predominant population of persons with MR as well as persons with severe physical disabilities receiving SE services. The first difference is the types of interventions. The SEIS contains three intervention categories involving job-site specific

Table 6. Type of Separation from Employment

	Persons with CMI		Non-CMI Persons	
Separation Type	*Number of Separations*	*Percent of Total*	*Number of Separations*	*Percent of Total*
Resigned	75	58.6%	526	44.0%
Laid off	11	8.6	187	15.6
Terminated	41	32.0	466	39.0
Leave of absence	1	0.8	15	1.3

Table 7. Primary Reason for Separation from Employment

	Persons with CMI		Non-CMI Persons	
Reason for Separation	*Number of Separations*	*Percent of Total*	*Number of Separations*	*Percent of Total*
Low-quality work	6	4.7%	64	5.4%
Poor attendance	7	5.5	71	5.9
Insubordination	7	5.5	58	4.9
Aberrant behavior	4	3.1	34	2.8
Poor work attitude	6	4.7	83	6.9
Not wanting to work	19	14.8	109	9.1
Economic situation	9	7.0	173	14.5
Medical health problem	17	13.3	56	4.7
Better job	16	12.5	134	11.2
Poor job match	9	7.0	42	3.5

activities. These categories include active and inactive time on the job site and direct employment advocacy time. Approximately 57% of the employment specialists' time is spent at the job site for the CMI population, and 67% for the non-CMI population. For the CMI population, more emphasis is placed on advocating for the supported employee with supervisors, coworkers, and customers, and less time is actively involved with the individual worker in training as compared to the non-CMI population. *However, the majority of reported intervention time for the CMI population is at, and not away from, the job site.* In the only other published study of actual job-coach intervention hours, Fabian and Wiedefeld[29] report that approximately 20 hours per week for the first month is spent by the job coach *on site* (for participants averaging 27.4 hours per week working). Although no actual data exists on the distribution of the job coach's time over various types of interventions or on the total number of service hours per year, they do note that the job coach tends to spend his or her time in modeling social interactions with coworkers and supervisors and developing strategies to increase production rate rather than in direct training in the technical skills of the job.

Persons with CMI comprise the one population exempted in the federal regulations for SE from the extended service requirement that two job-site visits per month for the purposes of skill training be provided.[1] The indications in the Fabian study and in the current Virginia study are that substantial intervention time for the CMI population occurs at the job site. These findings merit attention in terms of the basis for the regulatory exemption for the CMI population from required job-site interventions and design of SE services for the psychiatrically disabled.

Several other points need to be made regarding the pattern of intervention hours. Of importance is the greater amount of time spent on-site in direct employment advocacy and off-site in consumer training and indirect employment advocacy for the CMI population, than for the non-CMI population. It seems that people with psychiatric disability generally can learn the technical skills of the job quickly but require much more assistance in coordinating services and supports outside of work area in learning skills that are not directly job-task related. Also, the employment specialist spends more time in educating and enlisting the support of coworkers and supervisors. People with psychiatric disability have complex service needs,[26] such as case management, residential, therapy, crisis management, education, medical, and so on, and may be involved with a variety of providers. Job coaches must coordinate efforts with these other providers to increase the support for the worker's success on the job (e.g., negotiating an evening therapy appointment time, informing the psychiatrist of adverse medication side effects, or assisting the case manager in advocating with the Social Security Administration about financial benefits). If support service needs are not being met currently, SE providers may spend a lot of time assisting the worker in identifying and accessing services to meet those needs (e.g., getting a case manager, therapist, psychiatrist, or vocational rehabilitation counselor, or arranging transportation).

The data presented here regarding a larger proportion of time spent training the consumer in skills other than those that are directly job related seem to support the notion that people with psychiatric disability need technical skill training less and more assistance in the social-emotional areas.[8,10,27] Henderson and Argyle[30] estimate that 35%–90% of work time is spent interacting informally. Given that people with psychiatric disability may experience deficits in social skills, off-site training in these skills seems indicated.

Because of the stigma and fear of mental illness, much more time working with coworkers, supervisors, and customers may need to be spent providing accurate information and reducing fear. Employers may also need specific suggestions about how to interact with the worker with the psychiatric disability. In addition, time spent developing natural supports in the workplace may improve job retention and job satisfaction.[27]

The data presented here regarding the "peaks" in service hours over time is similar to observations made by Fabian and Wiedefeld[29] and also supports the recommendation made by others that SE services be flexible to accommodate the episodic nature of the disability.[6,10] Employment specialists must be vigilant in regular follow-up with both employees and employers to identify any problems arising from an exacerbation of the illness.

Also of interest is the second area of differences in intervention. The total number of intervention hours provided to persons with CMI by Virginia's providers is 53.8% of the mean average total of 177.6 intervention hours over a 52-week period for the non-CMI population. In Fabian and Wiedefeld,[29] although not specifically reported, the total number of hours per year would seem to be higher than reported in this study (an average of 20 hours per week in the first month, plus a 2-hour-a-week support group, plus follow-up contacts). The findings of the Virginia study have potential implications in the determination of staff/participant ratios for staffing SE programs serving a generalized or disability-specific population and for projecting the funding requirement for persons needing SE services. For example, the mean average hourly rate in Virginia for the supported competitive employment model is $31.81 as of June 30, 1990.[32] Utilizing this rate, the 52-week cost for serving the CMI population reported in this study, as represented in Figure 1, is $3,038 as compared to $5,472 for the non-CMI population.

Cost comparisons should be qualified for a number of reasons. First, the comparative severity of disability across the two populations in the Virginia study cannot be quantified, and the possibility of subject selection bias referenced earlier does exist. Second, multiple provider agencies were involved in this study, and the consistency of staff skills, economic conditions, and service applications in communities across the state is not known.

Information is also needed on the variety of other services, such as case coordination and counseling, provided by agencies and/or persons other than the SE provider, as this also affects costs. SE provider time spent either arranging for or providing these services (in the absence of other community resources) may significantly affect employment outcome in addition to service costs. Third, caution should be used in comparing cost-benefits and outcome.

Anthony, Cohen, and Farkas,[33] in reviewing the literature, could find no causal relationship between the expenditures for a rehabilitation program and the outcomes of that program. That is, proponents of SE or any rehabilitation program for this population should not cite reduced costs as a reason to provide this service. Fourth, the SEIS contains data on 273,987 hours of intervention time for the non-CMI population as compared to 22,243 hours for the CMI population as of June 30, 1990. However, the data is based on a state-system effort to serve a varied population of persons with disabilities over a multiyear period, and to that extent, the translation of intervention hours into cost projection does have merit.

While noticeable differences in interventions were found in this study, there are also interesting points in the area of program outcomes. The two primary areas of differences between persons with psychiatric disabilities and the other populations studied are in job retention and in reasons for job separation. These issues are analyzed in greater depth in the remainder of this paper.

The job retention profile shown in Table 5 does indicate that persons with CMI separate from their initial placement at a noticeably higher rate than do persons in the non-CMI population. Poor job match was cited as a reason for separation twice as often for the CMI population than for the non-CMI population. Adjustments to the supported competitive employment model, developed initially for persons with MR, to place greater emphasis on the active participation of the CMI population in the *choice* of their job area, is viewed as a critical variable in job retention.[10] In addition to emphasizing interest and values in job selection, prior work skills, experience, and education might lead to identifying more compatible jobs outside the janitorial, food-service, and clerical areas. Fabian and Wiedefeld[29] found that 12% of those working were employed in skilled jobs. In terms of education, 34% had some college and 36% had a high school diploma. Harrison and Perelson[9] wrote that program participants were employed in positions such as dialysis patient assistants and laboratory assistants.

Job retention is a major issue to funding agencies investing in SE services. Substantial attention is needed for the factors potentially influencing job retention for the CMI population, including appropriateness of the initial job match; support services provided during the period of employment (both vocational and therapeutic); extent to which the jobs utilized by the SE program provide the needed level of income and benefits; and the influence of the cyclical nature of mental illness.

It may be helpful to examine several issues related to job retention by reviewing the data compared to base rates of employment, job tenure for nondisabled entry-level workers, and vocational maturity and career development. One way to evaluate the success of SE is to compare job tenure rates to base employment rates in the literature. Anthony[34] reported a 30%-50% employment rate at 6 months, 20%-30% at 12 months, and 25% at 3-5 years for people discharged from the hospital. However, if the criterion for comparison is either working full-time during the entire follow-up period or employment at the time of follow-up (versus employment at some point during the follow-up period), employment rates drop to 20%-25% regardless of which follow-up time period is used. In view of this data, job retention rates in the Virginia study are better than base rates of employment up until the 18-month follow-up period, at which time rates are comparable. These rates are measurably better than the 0%-15% employment rates reported by Anthony and associates for people who have severe psychiatric disability.[15,34]

Job tenure and retention should also be considered in light of job-tenure rates reported for people without disabilities. Most placements in this study were in entry-level jobs. The average job tenure for nondisabled Americans in entry-level jobs is six months.[35] Professionals must be careful not to expect more of people with disabilities than is expected of people without disabilities. "Success" might then be defined in terms of the number of months of employment in any given follow-up period and of the number of levels of job advancement during follow-up in addition to the level of participant satisfaction with the job and the service.

This leads into a discussion of assessing SE outcome from a career-development perspective. Many people who have psychiatric disability first experienced illness during adolescence and young adulthood, when most nondisabled people are working at summer jobs and part-time jobs, going to school, and developing a vocational identity. Successive, short-term employment experiences (in regard to job tenure) may represent a need to "catch up" in vocational development. Given that the CMI population in this study is somewhat older than the non-CMI population (34.5 years versus 28.9 years), there may be a greater sense of urgency to catch up to their similar-age, nondisabled peers. These experiences then provide the basis for a person to make sound vocational decisions and plans for the future.[36,37] The Fountain House report of TE indicates that employment experiences accumulate over time, producing better long-term outcomes the further away from service provision that one goes.[25] This would suggest the need for long-term follow-up on SE outcomes.

The issue of job selectivity and job satisfaction also needs attention. Table 4 shows that nearly one-half of the jobs utilized for the CMI population were in the food- or janitorial-service areas. Recent data in Virginia indicates a trend toward employment in office and stock clerk job areas and away from the service industries for all populations. Possibly related to the impact of job selection on job satisfaction and job retention is the finding shown in Table 6 that the CMI population studied initiates job separations at a noticeably higher rate than does the non-CMI population. It appears that greater attention is needed, during the job-selection process and during the period of employment itself, to the work-satisfaction issues experienced by the CMI population if job retention is to be improved.

Another way to improve job retention is to examine the reasons for job separation (Table 7). Of the CMI population, 14.8% left jobs because they did not want to work. In addition to examining this question prior to selecting a job, the issue should be analyzed in greater depth to identify the factors contributing to this decision (i.e., fear of high expectations once paid for working, losing benefits, loneliness, or feeling out of place). Interventions then might involve modification of the SE model, advocating with Social Security, establishing natural supports in the workplace, or using a variety of other creative solutions.

Medical health played a role for three times as many persons with CMI (13.3%) as with non-CMI populations (4.7%). There may be a number of reasons for this. First, psychiatric disability is variable and episodic in nature, compared to most physical disabilities and MR. Hospital recidivism rates are 35%–50% at 1 year and 65%–75% at 3–5 years.[11] Community support programs and psychosocial rehabilitation programs appear to be effective in reducing recidivism rates.[23,28]

It also appears that the prevalence of medical illness among people with severe psychiatric disability in outpatient care is quite high. Maricle and colleagues[38] found that 88% of study subjects had one significant medical illness; 51% had been previously undiagnosed. This finding points to the need for service coordination addressing the health needs of people with psychiatric disability. One must interpret these results cautiously, as the average age in this study was slightly older (43 years versus 34 years). In comparing this reason for separation to nondisabled entry-level workers, one study reported that 8%–9% were terminated from employment for health reasons.[39]

The last major reason for job separation for the CMI population was that of taking a better job. As discussed previously, it may be a positive sign that workers are interested in career development and advancement and that shorter job tenure may not necessarily indicate poorer SE outcomes. The types of jobs may not represent the range of interests found in this population.

CONCLUSION

This study presents preliminary data comparing people experiencing psychiatric disability and people with all other disabilities. Future research should focus on defining the target populations more accurately, analyzing the reasons for job separation, particularly that of not wanting to work (for the CMI population), and conducting long-term follow-up studies to determine SE program effectiveness, with attention to cumulative impact of employment experiences. Outcomes should be analyzed taking a career-development perspective into account. Success should be measured in terms of the number of months of employment during follow-up rather than in terms of job tenure in a single job.

This study addressed a general population of persons with a primary disability classification of emotional disorder/CMI served by a variety of provider agencies. Limited information was available on mental health-oriented support services provided in companion with SE services. Future research should focus on more clearly defined populations of persons with psychiatric disability in terms of length of illness, number of hospitalizations, employment history, and support services received. The Virginia study indicates that persons with a psychiatric disability can benefit from SE services and that there are noticeable differences in service patterns and outcomes for this population when compared with a predominant population of persons with MR. The further evaluation and refinement of SE services for the psychiatrically disabled will require more research-based information on well-defined populations, services, and supports.

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INDIVIDUAL PLACEMENT AND SUPPORT: A COMMUNITY MENTAL HEALTH CENTER APPROACH TO VOCATIONAL REHABILITATION

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INDIVIDUAL PLACEMENT AND SUPPORT: A COMMUNITY MENTAL HEALTH CENTER APPROACH TO VOCATIONAL REHABILITATION

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ABSTRACT: Individual Placement and Support (IPS) is a vocational rehabilitation intervention for people with severe mental disabilities. The model draws from components and philosophies of other successful programs. Employment specialists, who are part of the community mental health center team, provide services in the community. IPS emphasizes client preferences, rapid job finding, continuous assessment, competitive employment, integrated work settings, and follow-along supports. Initial research on IPS shows favorable results.

Competitive work is increasingly a goal for persons with severe mental disabilities. Like others in American society, people with psychiatric impairments want to lead normal lives and view work as one of the principal signifiers of normal adult life. In a statewide survey of people with severe and persistent mental illness, 71% of those without jobs expressed an interest in paid employment (Rogers, Walsh, Masotta & Danley, 1991). At any one time, however, less than 15% of those with severe psychiatric disabilities are employed (Anthony & Blanch, 1987).

Despite their own interests, people with severe mental disabilities have received little assistance in gaining competitive employment. Only 3% of those in a national survey had been in supported employment programs (Tashjian, Hayward, Stoddard & Kraus, 1989). Moreover, between 1977 and 1984, competitive employment for Vocational Rehabilitation (VR) clients with severe psychiatric disabilities did not improve (Andrews, Barker, Pittman, Mars, Struening & LaRocca, 1992).

Until recently, community mental health centers (CMHCs) did not emphasize vocational services (Black & Kase, 1986), in part because mental health professionals saw their role as protecting clients from stressful situations, including employment. Independent psychosocial rehabilitation programs and nontraditional rehabilitation agencies have historically provided what little vocational services were available (Katz, 1991).

As CMHCs begin to emphasize vocational services, models that have shown successful outcomes are being considered for replication. Current vocational approaches include sheltered work, psychosocial rehabilitation (e.g., clubhouses with transitional employment), skills training, assertive community treatment, supported employment, and job clubs (Bond & Boyer, 1988). Instead of transplanting a vocational model exactly as it has been implemented elsewhere, however, several experts recommend adapting a model, or parts of several models, to fit the needs of a particular agency, clientele, and community (Bachrach, 1988; Stein & Test, 1985; Witheridge & Dincin, 1985). New models should be described with unambiguous terms, standard definitions, and clear outcome criteria (Bond and Boyer, 1988; Bond and McDonel, 1991).

The purpose of this report is to describe a vocational rehabilitation model, Individual Placement and Support (IPS), that has recently evolved in several New Hampshire CMHCs. IPS is a team-oriented, CMHC vocational service that assists persons with severe mental disabilities in obtaining and maintaining competitive employment. IPS emphasizes client choice, rapid job finding, competitive jobs, integrated work settings, and follow-along support services. Excluding clients from employment services, extensive initial assessments, and pre-vocational training are de-emphasized. Two current studies of IPS in New Hampshire are revealing positive vocational outcomes (Drake, Becker, Fox, & Lounsberry, 1992; Drake, Torrey, Wyzik, Becker, & McHugo, in preparation).

PRINCIPLES

IPS was developed by considering the philosophies, values, and critical components of several approaches to vocational rehabilitation in relation to the particular characteristics of the New Hampshire public mental health system. It draws most heavily from the Program of Assertive Community Treatment (PACT) in Madison, Wisconsin (Russert and Frey, 1991; Test, 1991a). Other influences include the supported employment movement (Federal Register August 14, 1987; Wehman, 1986), Boston University's

Center for Psychiatric Rehabilitation (Anthony; Cohen, & Farkas, 1990), and several thoughtful reviews of the empirical literature by Bond (Bond & Boyer, 1988; Bond & McDonel, 1991). IPS incorporates the following principles.

1. *Rehabilitation is an integral component of mental health treatment.*

IPS assumes that nearly all people with severe mental disabilities can engage in some type of work and that work is good treatment. Furthermore, because symptoms and disabilities are intertwined, rehabilitation and other treatments require careful coordination. That is, work and therapy are dynamically interactive; each influences the other. While some vocational models attempt to separate rehabilitation from other treatments, IPS integrates them closely.

Rehabiliation is therapeutic in several ways. Work can lead to changes in motivation, self-confidence, structured activities, and relationships. In addition, work often impacts directly on the client's psychiatric disorder. Though work can increase stress and the need for medications, it often motivates clients to improve their self-management of symptoms and may reduce the need for medications. In a reciprocal fashion, other treatments influence rehabilitation. For example, addressing medication noncompliance and interpersonal difficulties, which are often impediments to long-term employment, can improve the effectiveness of rehabilitation.

2. *The goal of IPS is competitive employment in integrated work settings.*

Clients in a statewide survey (Rogers et al., 1991) and in our focus groups in New Hampshire indicated a preference for competitive jobs in integrated work settings (i.e., settings that contain non-disabled workers) rather than sheltered or volunteer work. Although research has not shown that integrated work settings are always more beneficial than sheltered settings, integrated work settings are more normalizing. Clients report that they feel stigmatized in enclaves of other disabled workers. IPS follows a place-train strategy (Wehman, 1986) in which clients enter competitive jobs and receive needed training and support on the job. Some clients will inevitably need to transition through volunteer jobs or other pre-vocational activities. Nevertheless, since expectations tend to provide a self-fulfilling prophecy, and low expectations (e.g., sheltered employment) may result in clients failing to fulfill their wishes and potentials, IPS focuses consistently on competitive work as the ultimate goal.

3. *People with severe mental disabilities can obtain jobs rapidly.*

IPS emphasizes entering work as soon as possible rather than preparing for work. Newman (1970) described several advantages of rapidly obtaining employment in terms of assessing employability, reinforcing capabilities, and experiencing the worker role. Bond and Dincin (1986) found that clients were more likely to engage in competitive employment if they participated in an accelerated placement program rather than a prevocational program. Their clients expressed dissatisfaction with prevocational assessments and training, and preferred rapid placements in real jobs in the community. Focus groups in several New Hampshire CMHCs confirmed that clients prefer to seek jobs without lengthy prevocational training and assessment.

4. *Vocational assessment is continuous.*

IPS incorporates assessment as an ongoing process that continues after acquiring a job (Wehman, 1986). Each work experience provides more data about the client as a worker and helps in planning for the next job. Job endings are, therefore, always framed in positive terms. This approach contrasts with traditional programs in which clients' vocational abilities are assessed through extensive tests and evaluations conducted prior to acquiring employment.

5. *Follow-along supports are often necessary to sustain employment.*

Job retention is more difficult than job finding for many people with severe mental disabilities. Follow-along support includes any services that assist clients in keeping their jobs – e.g., transportation, advocacy and education with the employer, and counseling about work relationships. The levels and sources of support vary depending on the clients' needs.

6. *Services are based on clients' preferences and choices.*

Services are client-centered in both planning and delivery. IPS encourages clients to participate as much as possible. The New Hampshire mental health system has been based on a collaborative philosophy for many years. Treatment planning occurs in regular client-centered conferences.

This philosophy has been applied to vocational rehabilitation at the Boston University's Center for Psychiatric Rehabilitation by conceptualizing the process from the client's perspecitive – i.e., choosing, getting, and keeping a job (Anthony, Howell & Danley, 1984). Those clients who are unable to express their views, make choices, and initiate activities independently can also fit easily into IPS because it is implemented in a highly individualized manner. Depending on levels of disability and verbal, cognitive, and interpersonal skills, clients need varying degrees of staff guidance and support in finding, acquiring, and maintaining a job.

7. *Services are usually provided in the community.*

Client contact and training is *in vivo*, in the client's natural environment. This approach has several advantages: Since skills learned in the CMHC do not generalize, clients learn skills in community settings where they are used. Clients feel empowered when meeting CMHC staff in a setting more neutral than the clinic, which may be perceived as stigmatizing. By observing people in their natural environment, the employment specialist can assess clients' needs, behaviors, and support networks more directly. Assertive outreach in the community is often essential. Clients sometimes disengage when they are fearful, discouraged, or pressured by network members not to work. Employment specialists can reach out at these critical times to provide necessary support and encouragement.

8. *A team approach promotes integrated services.*

A team approach with regular communication between the employment specialist and other treatment team members permits the careful integration of mental health and rehabilitative services. Symptoms, illness management, interpersonal behaviors, and activities and relationships on the job are interrelated. The employment specialist, for example, conveys pertinent job-related information such as job starts, terminations, and work problems. The employment specialist may also identify symptoms that occur at work. The case manager, the nurse, and the psychiatrist in turn inform the employment specialist of changes in the client's medicines, living arrangements, and important relationships. They describe both chronic interpersonal difficulties that are likely to arise on the job and prodromal symptoms. The team collaborates with the client as these interactions inevitably shift with changes in vocational status.

The forum in which the employment specialist communicates with other members of the treatment team varies depending on the organizational structure of the CMHC. IPS was designed in New Hampshire to be implemented in CMHCs that have teams of clinical case managers with caseloads of approximately 20-30 clients per case manager (Kanter, 1989; Harris & Bergman, 1988). Employment specialists regularly attend case management meetings and treatment team meetings.

PROGRAM DESCRIPTION

A staff of employment specialists, integrated with the CMHC treatment team, implement the IPS program and provide liaison with other agencies. The program will be described in several phases including referral, engagement, assessment, acquiring employment, and job support.

Organization

The IPS program is staffed by a vocational coordinator and two or more employment specialists. The program coordinator, who typically has a master's degree in rehabilitation, supervises the employment specialists, works with referrals, and acts as administrative liaison to other departments and programs. Employment specialists carry caseloads of 20-25 clients, varying with the level of client needs, and usually work in pairs to cover for each other. This staffing arrangement also provides a staff support system.

Employment specialists come from a variety of backgrounds, but the most successful ones are assertive, high-energy, task-oriented, and optimistic. They firmly believe that most people can work if the right situation is found. They also believe in doing the job outside of the clinic, in the community. Other qualifications include: knowledge of severe mental illness, including diagnoses, medication management, and treatment; knowledge of a broad range of occupations and jobs; ability to interact with employers; assessment and counseling skills; and ability to work as a team member with staff from other disciplines.

While the core of IPS is integrating vocational services with other CMHC services, employment specialists also link clients with outside agencies, such as private vendors, the Department of Employment Security, and the Division of Vocational Rehabilitation (VR), as needed. For example, VR can provide additional assessments, training, job-related equipment and supplies, placement, and support. VR may also purchase IPS services. CMHC and VR offices typically develop official agreements, but the personal relationship between VR counselor and IPS employment specialist is critical.

Referral

Clients can be self-referred or referred by family or CMHC staff. Those who are 18 years and older and have a major mental illness that qualifies them for services in the CMHC's community support program are eligible. The only additional requirement is expressing interest in competitive employment. IPS assumes that clients can make appropriate choices about their own rehabilitation program. After attending an educational group, clients make an informed choice about whether to participate (Drake, Becker & Anthony, in preparation). Consistent with our philosophy of attending to clients' preferences and maximizing vocational outcomes for all, clients are rarely screened out by staff. Our research indicates that a high proportion of those who select IPS are able to obtain competitive jobs.

Engagement

Upon starting the IPS program, clients are linked with an employment specialist with whom they meet individually. Establishing a trusting, working relationship with the client is the *sine qua non* of vocational rehabilitation. Some clients prefer not to meet at the CMHC because of the stigma about mental illness. Getting to know clients in the community, in their world, allows the employment specialist to observe relationships, daily routine, home environment, interests, and habits -- all of which are useful for job exploration and assessment.

Readiness for work of course varies. Some clients want to go to work quickly; others express an initial desire to find a job, but then back off from any activities related to a job search. The employment specialist meets regularly with clients, even if they do not always talk specifically about work. If a client drops out at any point, the employment specialist reaches out in an assertive manner to attempt to renew the process.

VocationalAssessment

The initial vocational assessment includes the client, the CMHC staff, the case record, family members, and previous employers. Key data include work background (education and work history), current adjustment (physical health, endurance, grooming, interpersonal skills, medication management, symptomatology), work skills (job-seeking skills, job skills, aptitude, interests, motivation, work habits relating to attendance, dependability, stress tolerance), and other work-related factors (transportation, family support, substance use, expectations regarding personal, financial and social benefits of working). The goal is to specify a first job. Afterward, assessment occurs continuously as the client and employment specialist learn what kinds of jobs and supports are likely to be successful and satisfying.

Job choices should be congruent with client's abilities, preferences, and style. The IPS employment specialist tries to help the client find a job that is tailored to his or her needs rather than to change the client to fit a specific job. For example, if a client has a long history of poor hygiene and grooming, despite previous efforts of others to help the client change, they find a job that accomodates this appearance. The nature of the psychiatric disorder often determines the optimal type of job, the work environment, and needed job supports. The client who has paranoid, referential thoughts around people might not do well as a food server in a fast-food restaurant, but might feel comfortable preparing food alone in the kitchen. Someone who continually feels anxious and restless might not be suited for a desk job but might excel in a delivery position. A client who shouts at hallucinatory experiences might have difficulty in a quiet office but might do well in a noisy outdoor work setting.

The goal of IPS is competitive employment in integrated settings with follow-along supports, yet some clients feel so overwhelmed that they will only consider volunteer or sheltered jobs as a first step. Clients can gain confidence and good work habits through volunteer or sheltered jobs (e.g., workshop jobs or CMHC-based sheltered jobs), but these settings can also reinforce dependency. IPS therefore emphasizes competitive work, even if only a few hours per week with supports, to gain experience.

Each IPS client has an employment plan that includes vocational goals, timelines for achieving the goals, supports needed for obtaining the goals, and people responsible for implementation. The vocational plan, modified as needed by new information, is incorporated into the client's individual CMHC treatment plan.

Obtaining Employment

When job preferences have been identified, the employment specialist and client work together to find a job in the community. In the job-seeking process, the client takes the lead as much as possible. Some clients do not want the employer to know about their mental illness or their involvement with the CMHC, so the employment specialist assists indirectly in the job search. For example, the employment specialist coaches the client about job interviews but does not attend the appointments. For some clients, however, psychiatric symptoms interfere with developing the skills to negotiate a job with an employer, so someone else must help to secure the job. Even if the client can obtain a job independently, the client often agrees to the employment specialist contacting the employer in order to assist with potential problems. The employment specialist provides education, guidance, and support to the employer as needed.

Employment specialists help with the job search in varying ways. Their approaches are creative, flexible, and imaginative. They may review newspaper want ads, but nontraditional approaches seem to be more successful. Some go unannounced to a business, to learn about its operation, needs, current job openings, and possibilities for future opportunities. They also find openings in new businesses that are hiring personnel, in businesses that are expanding, and from employers at the Chamber of Commerce. A major source of leads is through personal contacts. Employment specialists talk to as many people as possible about the types of jobs they are seeking. They talk to their own family and friends, other staff, and family members of clients. Members of the Alliance for the Mentally Ill are often helpful. Through all employer contacts, employment specialists build a network of employers to whom they can refer clients as job candidates.

Sometimes a job must be created. For example, an employment specialist whose client enjoyed landscaping went to a local fast-food restaurant for dinner and noticed the unattractive grounds around the restaurant. She asked to speak to the restaurant supervisor and told him about her client. The client was hired on a time-limited basis, and soon after, the job became a permanent part-time position.

When negotiating a job, the employment specialist provides the employer with several benefits. These include knowledge of the client, ongoing supports, crisis intervention, and information about employment practices, such as the Americans with Disabilities Act and the Targeted Jobs Tax Credit. Our experience indicates that employers are interested in all of these.

Job Support

When the client is working, the employment specialist provides follow-along support to the client and the employer. They discuss problems as they occur. The client may need frequent contacts initially, even daily meetings to go over what happened at the job. Although on-site job coaching is available, most people with severe mental illness need minimal assistance in this area. They benefit instead from guidance and support that is provided away from the job site to address difficulties such as interpersonal relations.

The employment specialist sometimes intervenes if a potential problem appears. For example, with the help of his employment specialist, a client acquired a job at a fast-food restaurant doing counter work for 20 hours per week. After two weeks, the restaurant manager offered to increase his weekly work hours to 40. The client expressed interest in working full-time, but the employment specialist knew that in previous jobs the client had become overwhelmed and had lost jobs when he increased his work hours. The employment specialist discussed with the client the previous work pattern and suggested that it might be best to continue with part-time employment and slowly increase to full-time work. The client asked the employment specialist to talk with the employer about the work hours, and the employer subsequently adjusted the work hours to a part-time schedule that proved to be manageable for the client.

After a client has been working, the need for the employment specialist's involvement often decreases and becomes sporadic. Clients typically do well but have periods of difficulty as symptoms of the illness or interpersonal problems arise. At these points, the employment specialist may help the client to negotiate a reduction in work hours or a leave of absence, or just increase supports. With appropriate supports, work can be a stabilizing factor during difficult times.

Along with the employment specialist, other treatment team members provide services that help the client to maintain employment. The psychiatrist adjusts medication as needed. The case manager provides support to the client on vocational concerns and other areas in his life that may affect his work performance. One client, for example, struggled with expressing sexual urges inappropriately at work. The client met with his case manager to discuss how to prevent this problem from interfering on the job.

DISCUSSION

IPS is an eclectic approach; it represents an amalgamation of other prominent models of supported employment. Since it was developed specifically to fit in New Hampshire's CMHCs, its success may be related to the context. New Hampshire's ten community mental health centers are relatively well-supported small programs that emphasize comprehensive services for people with severe mental disabilities. They are located in small cities or towns with populations of between 60,000 and 150,000 people. In other settings, with larger populations, less coherent mental health systems, or systems with a different orientation, the IPS model may be more difficult to implement.

One unusual feature of the New Hampshire mental health system is its emphasis on mental health services research. The New Hampshire-Dartmouth Psychiatric Research Center is an integral part of the Department of Mental Health (DMH) and participates in planning, implementing, and evaluating many programs (Drake & Teague, 1990). Research data are used continuously in the process of modifying programs and shifting resources from ineffective programs to those that achieve better outcomes (Drake, Becker, & Bartels, in press). As the IPS model began to emerge in New Hampshire, DMH sponsored conferences and meetings to clarify the model and moved rapidly to evaluate the model.

Because IPS is part of an extensive research program, a detailed treatment manual (available from the authors) has been developed, clinicians have received specific training and supervision in the model, and services and outcomes are tracked carefully. Two research projects on IPS are currently underway in New Hampshire. In the first, which is sponsored entirely by DMH, one CMHC agreed to close one of its two day treatment facilities and to convert the staff positions to IPS employment specialists. Clients in this program have been followed longitudinally and compared with those in a similar day treatment facility, which did not close, in the same CMHC. One-year outcomes indicate that both volunteer jobs and paid jobs increased in the program that converted to IPS. For example, 55% of the high utilizers of day treatment services in the converted program secured a paid job in the community within one year of the program change compared with only 8% of similar clients in the unmodified program (Drake et al., in preparation).

The second project, which is funded by the National Institute of Mental Health, compares IPS with vocational services provided by a private vendor outside of the CMHCs. Clients who are randomly assigned to IPS or the private vendor are being followed carefully for 18 months. The project includes an ethnographic component to elucidate key process issues and a cost-effectiveness component to identify the costs of providing vocational services in the two ways. This experiment is in progress, but one-year results favor IPS and are consistent with the findings of the first study. Thus, a strong empirical base for IPS is rapidly emerging.

Despite these findings, we as yet have no data on the long-term effects of IPS. Clients' vocational careers over a number of years should be studied in detail to understand their evolution and the factors that determine long-term success and the relationship to quality of life, symptoms, community tenure, and other important outcomes. Vocational adjustment should be considered in terms of a career, not just short-term success. Recent evidence indicates that the success in vocational adjustment associated with PACT treatment attenuates over time (Test, 1991b). IPS, which emphasizes rapid placement, may also have greater initial success than long-term success. While short-term success has value in its own right, studying the long-term impact of early job acquisition is critical.

Persons with severe mental disabilities, like the rest of us, are undoubtedly acculturated into their roles and self-images as workers or non-workers. Rehabilitation specialists have sometimes argued that mental health settings are stigmatizing and socialize clients into dependence and disability (Anthony et al., 1990). The IPS model explicitly directs employment specialists and clients to focus on competitive jobs in integrated work settings in the community, but places the vocational staff within teams in the CMHC to facilitate clear communication and coordination. Our research indicates that interorganizational communication difficulties and conflicts often arise when vocational services are provided by an outside vendor.

A further unanticipated advantage of the IPS model is that organizing vocational services under the auspices of the CMHC influences how case managers and other staff regard vocational goals. Many of the same clinicians who were previously indifferent or even skeptical toward vocational rehabilitation have been positively affected by IPS and, despite their initial resistance, have become advocates for vocational services. Their conversions appear to affect the culture of the mental health centers.

SUMMARY AND CONCLUSIONS

IPS offers supported employment as an integrated component of the CMHC treatment program. The treatment team collaborates in supporting clients in their vocational pursuits. Clients rapidly obtain competitive jobs that are congruent with their personal preferences and their clinical and rehabilitative needs. Vocational assessment is an ongoing process that incorporates information from each additional job experience. Ongoing supports are arranged to enable the client to keep the job, but job endings are viewed as opportunities for learning rather than as failures. The short-term success of IPS, in terms of obtaining jobs and modifying the culture of CMHCs, appears to be excellent. Because IPS is being developed in association with a mental health services research center, its outcomes and cost-effectiveness, including long-term impact, are being studied carefully.

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MENTAL ILLNESS AND SUBSTANCE ABUSE

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1

Dual Diagnosis: Fact or Fiction?

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Dual diagnosis, simply defined, refers to the concurrence of two separate diagnostic entities in one person. In the area of substance abuse, this means that a substance abuse disorder such as alcoholism occurs together with a psychiatric disorder such as major depression or panic disorder. In most situations, there are actually many concurrent diagnoses. A cocaine user, for example, frequently uses alcohol or heroin to come down. If the same person has a bipolar disorder, he/she would have at least three separate disorders: cocaine abuse, heroin or alcohol abuse, and bipolar disorder. In this chapter, I will discuss how a diagnosis may be confused by the simultaneous occurrence of both a substance abuse disorder and a psychiatric disorder as well as by other substance abuse disorders or medical disorders either induced by substance abuse or occurring independently. Emphasis will be on what is known epidemiologically and clinically of dual diagnosis. Unfortunately, the instability of this patient population over time makes it difficult to follow the group for outcomes of treatment except for those who have a psychiatric disorder that they are self-medicating. The self-medicating group does quite well if the psychiatric disorder is recognized and given diagnostic-specific treatment negating need for further self-medication with recreational drugs. Research into clinical presentation and course of use of recreational drugs is further complicated even in a stable population by the fact that substance abusers often do not know the drug they have taken with any degree of certainty and in most cases do not know the dose or contaminants.

Want of clinical acumen, as well as economically or politically motivated desire to oversimplify diagnosis and management of substance abuse, leads to untold pain for patients and families and to compromised quality of care. Cost is greatest to the young, where concomitant undiagnosed and treated Axis I and II psychiatric disorders, coupled with substance abuse, contribute to the genesis of enduring patterns of maladaptive coping styles and diminished self-esteem. Unrecognized dual-diagnosed patients drain both public and private health care systems by repeated and lengthy hospitalizations. These individuals rapidly resume substance abuse after discharge and fail to comport to treatment plans. These people do not respond to the best of self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous. Some join the ranks of the homeless.

As many as 74% of psychiatric inpatients reportedly have abused substances [2]. Thirteen percent consistently abuse drugs other than alcohol. Frank alcoholism occurs in 8.7–17.1% of general medical patients [2]. Psychiatric patients admitted without diagnosed substance abuse problems have been found to differ from medical/surgical controls in quantity and frequency of drug use and problems associated with the drug used [2].

One of the principal clues to differentiating drug users with major psychiatric illness from those whose symptoms are primarily a response to drug abuse is onset of symptoms [3]. Patients with a long history of deterioration prior to hospitalization, as measured by duration of psychotic symptoms, previous psychopharmacotherapy, and poor occupational adjustment, are more likely to be dual-diagnosed. Pattern of drug use and presence or absence of violence does not have as great diagnostic significance [4]. Double depression (i.e., major depressive disorder superimposed on dysthymic disorder) occurs in this population and poses special problems. The double depression group exhibits significantly greater alcohol and amphetamine use [5]. Since both forms of depression are generally antidepressant respondent, identification of this subpopulation can lead to successful treatment of all three disorders: major depression, dysthymia, and substance abuse. Psychic suffering accompanying substance abuse, coupled with psychopathology, results in interpersonal difficulties and impaired social adjustment, contributing to a misimpression of a schizophrenic rather than an affective process [6].

The majority of patients with psychiatric problems are attended by primary care providers rather than mental health professionals, contributing in part to the appalling fact that only about 19% of those affected have been provided help for psychiatric disorders in the previous six months [7]. The impression of many nonpsychiatric health care providers is that substance abuse disorders are different from psychiatric disorders and should receive differential referral. After all, why are there three separate institutes at the National Institute of Health: the National Institute of Mental Health (NIMH), the National Institute of Drug Abuse (NIDA), and the National Institute of Alcoholism and Alcohol Abuse (NIAAA). Specialist, if not subspecialist, care is required to determine the role recreational drugs, concomitant medical and surgical illness, psychosocial variables, and preexistent or precipitated Axis I and Axis II psychiatric disorders play in the development of the clinical picture. Psychiatric disorders, medical disorders, and substance abuse disorders must be independently identified and differentially treated to reduce repeated and lengthy future hospitalizations. Both a differential diagnosis and a differential treatment plan must be elaborated.

SEXUAL DYSFUNCTION AND OTHER CONCURRENT MEDICAL PROBLEMS

Problems in sexual drive and/or performance frequently precede or correlate with substance abuse. These merit special discussion because, unlike many other medical problems, including the changes in hormonal function with alcoholism that lead to feminization, sexual dysfunction is more frequently due to psychological reasons than organic disease. As the old adage goes, alcohol increases desire but decreases performance. Actually, a small amount of *spiritus fermenti* was once recommended in *The Merck Manual* to overcome inhibitions that entrapped Victorian desire.

There are a number of ways in which drugs and alcohol impact sexual performance:

1. Sexual dysfunction may be a direct side effect of a drug.
2. Stress may lead independently to both sexual dysfunction and substance abuse.
3. Drug abuse may result from anxiety over sexual performance or lack of it.
4. Substance abuse may represent an attempt to self-medicate the primary psychiatric disorder.
5. Poor judgment attendant upon psychiatric disorders such as schizophrenia or medical disorders such as Alzheimer's disease or AIDS dementia may result in substance abuse.
6. Guilt over sexual prowess (e.g., multiple extramarital liaisons) may engender substance abuse.
7. Substance abuse may result from a pattern of socializing required to

meet sexual partners, as in the instance of depressed married men and women seeking homosexual companionship at gay bars.

8. Impotence or decreased libido may be entirely independent of drug use and due to physical and psychological factors that represent neither a drug effect nor a major psychiatric illness.

Drug-associated impotence has been reported to be as high as 25% [8]. Chronic airflow obstruction can occur contemporaneously with psychiatric problems and drug use, particularly alcoholism and inhalant abuse. Alcohol abuse is frequently seen in older age groups and in heavy smokers. Emphysema with air hunger is common in both groups. Of 50 consecutive patients with chronic lung disease in one study assessed both medically and psychiatrically, 58% were found to suffer panic and 34% other anxiety disorders [9]. The role substance abuse and other psychiatric symptoms plays in this group, as with impotence, is complex. Substance abuse may represent a response to anxiety associated with the illness. In other instances, a person may self-medicate the anxiety that is a symptom of air hunger occurring with chronic lung disease. In both instances, inhalant use or crack smoking may have contributed to lung problems. Finally, an independent psychiatric disorder (e.g., panic disorder) may coexist with substance abuse and pulmonary disease. Occurrence of three independent diagnoses, as in the case of alcoholism, panic disorder *not due to chronic airway obstruction*, and emphysema, is an example of triple rather than dual diagnosis. The addition of yet a fourth diagnosis, such as antisocial personality on Axis II, would result in a quadruple diagnosis [10].

Substance abuse is associated with a number of medical conditions that challenge even the most seasoned diagnostician. Historically, various forms of syphilis and tuberculosis confused all psychiatric pictures. Syphilis presents as general paresis, cerebrovascular syphilis, meningovascular syphilis, gummas, and tabes dorsalis. Tuberculosis causes tuberculomas, cerebral abscesses, tubercular meningitis, and the general neurasthenia associated with pulmonary and other forms of tuberculosis. Today, AIDS complicates the picture in a myriad of ways, ranging from depression in subclinical AIDS prior to confirmation by seroassay to AIDS dementia. Hepatitis, cirrhosis, and other liver diseases are associated with mood change [1].

Cocaine causes a number of cardiovascular changes, in addition to pulmonary and upper respiratory problems [1]. Skin and systemic infections are common sequelae of intravenous drug use. Drug abusers may present with bilateral pyopneumothoraces and bacteria from jugular vein self-injection [11]. Factors impacting on the occurrence of medical and dental complications include adulterants present when a drug is taken, nonsterile needles, overdose tolerance, extant dependence and withdrawal, life-style of drug user, and age of drug user [12]. Trauma is common with substance use. Unilateral or bilateral subdural hematomas from falls while intoxicated may present solely as depression or may be entirely overlooked because continued intoxication obfuscates recognition on exam in the absence of obvious clinical signs such as a unilateral dilated pupil. As serum alcohol level rises, the risk of any form of accident increases [13]. History of trauma may be a clue to undiagnosed alcohol abuse. Laboratory findings (e.g., elevated GGPT) appear to have a high sensitivity only with more chronic alcoholics and those who have ingested alcohol in the previous 24 hours [1,12].

Psychiatric symptoms reported as complications of AIDS and the AIDS-related complex (ARC) mimic a number of psychiatric disorders and precede seropositivity for HIV. These range from mild chronic dysphoria to acute psychosis. Early symptoms resemble those of advanced cocaine psychosis [14]. Both frequently appear in the same population, confusing the diagnostic picture. Agitation, panic attacks, anorexia, delusions, disorientation, insomnia, hallucinations, depression, impaired memory, and dysattention are reported. Seizures and tachycardia are also seen. Organicity should be suspected in all patients known to be seropositive. Intravenous drug users are the HIV-positive subpopulation that is most rapidly expanding. Heroin and cocaine are the preferred drugs for intravenous use [15]. In the population of IV drug users, acting out behavior due to central nervous system AIDS infection may be seen as sociopathy. In alcoholics, both young and old alike, the fluctuating consciousness of CNS HIV infection may be misconstrued as alcohol withdrawal delirium, and AIDS dementia as alcoholic dementia or Alzheimer's disease, depending on the age of the patient [16].

DUAL DIAGNOSIS AND ALCOHOL ABUSE

Alcoholism and Affective Disorders

Uncomplicated alcohol abuse is common only during the initial stages of drinking [1,12]. As desire to drink progresses, so too does frequency of dual or multiple diagnoses, complicating the picture. Therefore, it is rare to see an alcoholic who abuses only alcohol. Multiple drug use is more common [1]. In the final stages, the mental status picture represents the interaction of a number of acute and chronic factors such as delirium and intoxication superimposed on dementia and the other CNS consequences and liver failure.

Depression is usually present. The critical clinical question is not whether a depressed alcoholic suffering the psychosocial consequences of chronic substance abuse is feeling worthless and helpless but rather whether he or she has a treatable affective disorder and whether that affective illness preceded alcoholism. In the later instance, the drinking may represent self-medication of dysthymia.

The relationship between alcoholism and depression has long fomented debate. Schuckit feels this is due to confusing drinking, alcohol problems, and alcoholism on the one hand and sadness, secondary depression, and affective disorders on the other. Of the 80–90% of Americans who drink at some time during their lives, 10–30% develop alcohol-related problems. Only 8–10% of men and 3–5% of women, however, go beyond alcohol problems in their drinking to meet criteria for the diagnosis of alcoholism [17–19]. Many heavy drinkers are remorseful over the social and economic ramifications of their intemperance. Only a fraction of these have significant affective illness requiring more than detoxification and nonmedical rehabilitation. The group with both alcoholism and affective disorders requires greater deployment of medical resources for diagnostic-specific treatment in order to successfully avoid exacerbation of illness and consequences of untreated major affective illness. While one-third of alcoholic patients experience depressive symptoms, only 1–3% of alcoholic men are reported to suffer major depressive disorder [20].

The greater incidence of depressive symptoms as opposed to depressive illness found in actively drinking alcoholics is attributed to the physiological symptoms of withdrawal, the apathy of the alcoholic personality, the state of chronic intoxication, and concomitant drug use [21]. Severity of symptoms independent of affective illness is positively correlated with worse prognosis, suicide, and treatment attrition. For instance, a comparison of nondepressed and depressed alcoholics indicated that the latter have longer histories of problem drinking, more previous treatment for alcoholic misuse, more difficulty controlling alcohol consumption, more mental problems, and more physical symptoms related to alcohol abuse. They have a detached interpersonal style, distracted cognition, alienated self-image, and mixed depressed-anxious emotionality [22].

A number of clues facilitate identification of primary depression (antedating onset of alcoholism) and secondary depression. There is more impairment in patients with primary depression than in those with the secondary or concurrent type [20]. Age of onset and length of illness are two other factors discriminating primary from secondary depression; primary affective illness tends to last longer and have an earlier age of onset. Patients with depression secondary to alcoholism when compared to patients with depression secondary to nonsubstance abuse disorders, excluding schizophrenia, report less severe depression and tend to be predominately male [23].

Family history is important in identifying primary as opposed to secondary depression. Relatives of probands with subtypes of primary affective illness other than bipolar show a greater incidence of alcoholism in addition to affective illness [24]. Data are inconclusive. Other genetic studies indicate that depressives without alcoholism do not transmit alcoholism, while those with both alcoholism and depression transmit both, suggesting that alcoholism and depression are not manifestations of the same disease process [25]. Anxiety disorders are found more frequently in relatives of probands with alcoholism, suggesting self-medication in selected cases [26]. Families with a high incidence of alcoholism exhibit more dysthymic disorder and secondary depression rather than primary major affective illness.

A dose-response relationship between level of depression and alcohol consumption in alcoholic and nonalcoholic women has not been demonstrated. Personality disorder and anxiety level appear more influential. An inverse relationship between depressive symptoms and alcohol consumption exists among healthy women. Nonalcoholic dysthymic women consume significantly more alcohol than major depressive, subclinically depressed, and psychotic nondepressive women and less than the healthy nondepressed population. There is no difference in consumption among major depressive, dysthymic, and other diagnostic groups among alcoholic women. Progression of alcoholism is related to progression of depressive symptoms and correlated with increasing dementia in older age groups [27].

Groups at highest risk for the dual diagnosis of affective illness and alcoholism are females ages 20 through 30, individuals not presently married [28], and patients of low social class [29]. Family history of alcoholism or behavior associated with alcoholism does not differentiate primary alcoholics, alcoholism with secondary affective disorder, and primary affective disorder with secondary alcoholism. The three groups do differ, however, in past personal history and family history of affective disorder and time spent in hospital for both alcoholism and affective disorder. Risk is greater with patients with anxiety disorders and antisocial personality [30,32]. Higher prevalence in the latter group may relate to concomitant factors such as young age and more familial psychopathology, drug use, and subjective anger.

Alcoholics have reason to be depressed. They experience family disintegration, poor social and work role performance, and a myriad of medical problems. Infections, pancreatitis, cirrhosis, and arthritic diseases may themselves contribute to depression [33,34].

In a study of 49 severely depressed alcoholics, 80% with an initial major depression by Research Diagnostic Criteria were no longer depressed two weeks after cessation of drinking, indicating need for at least two weeks of sobriety prior to use of antidepressant therapy [35,36]. Chronic ethanol ingestion may lead to disturbance of the diurnal rhythm of cortisol secretion or stimulation of the adrenocortical activity, raising plasma cortisol levels in chronic alcoholics that is positively correlated with manifest depression [37].

The dexamethasone suppression test (DST) may facilitate rational selection of the subpopulation of alcoholics who will benefit from antidepressant therapy, but false positive results exist with this test [38]. False positives result from hepatic enzyme induction, acute alcoholic withdrawal associated with hypercortisolism and Cushing's disease.

Prognosis of alcoholic patients with affective illness is better if diagnostic-specific treatment is provided for the mood disorder [28]. Incidence of severity of depressive symptoms is greater in alcoholics who relapse than in the general population [39-41]. Debilitating depressive symptoms may first emerge in periods of abstinence. A study of 72 alcoholics abstaining a mean of 64 months revealed a 15% incidence of depressive symptoms beginning after a mean of 35 months of sobriety [42]. Rate for relapse was higher in the symptomatic group. Lithium reduces alcoholic abuse but not depressive symptoms in this group [43]. It is hypothesized that the group that benefits most is cyclothymic, with alcohol abuse exacerbated in the hypomanic rather than depressed phase. Other studies confirm that past psychiatric history is predictive of outcome in both alcoholics and narcotic addicts [44].

Depressive symptoms, as opposed to depressive illness, decrease markedly without treatment as patients progress from active drinking to abstinence [45]. Symptomatic mood changes without affective disorder may relate to major physiologic changes attendant upon alcohol use that abate as drinking ceases, with a concomitant decrease in depressive symptoms. Regardless of what the depressive symptoms relate to, however, depression as measured by the Beck Depression Inventory and Hamilton Psychiatric Rating Scale for Depression in alcoholics directly correlates with self-reports of previous suicide attempts [46,47]. Numerous other studies document the incidence of depression and depressive symptoms among alcoholics [48].

Impact of antidepressants on depression associated with alcoholism is contingent on whether the mood change represents true affective disorder rather than psychological response to a person's feeling out of control with his or her drug use in the absence of genetic predisposition and subsequent manifestation of a DSM-III-R mood disorder. In the absence of diagnostic-specific indications, there is little evidence of efficacy [49].

Psychosocial support mollifies depression associated with perceived consequences of alcoholism [50]. Reordering the social and personal life of the alcoholic and reinforcing valued nondrinking social ties the alcoholic has developed serves to reduce the depression in those without true affective illness. Patients who have a history of drinking primarily to facilitate social aspects of their lives are most likely to have residual depressive symptoms after treatment of alcoholism, indicating need to work aggressively with these patients to develop alternate means of social interaction.

Alcoholism and Nonaffective Psychiatric Disorders

Less attention has been afforded to concurrence of alcoholism and other psychiatric disorders except for the anxiety disorders already mentioned. Affective illness and anxiety disorders are far more prevalent, and therefore their relationship to alcoholism is easier to study than illnesses with significantly lower prevalence.

Alcoholism is a significant problem for schizophrenic patients [51] but not to the reported degree for mood-disordered patients [52]. Studies of monozygotic and dizygotic twins indicate that alcoholism and schizophrenia are more common in the monozygotic group, suggesting that individuals suffering from both schizophrenia and alcoholism have a genetic predisposition to both disorders of the same nature as that which occurs when alcoholism and schizophrenia appear alone. Schuckit points out that primary alcoholism can mimic almost any psychiatric disorder and that secondary alcoholism can exacerbate any psychiatric symptoms [19].

Diagnoses of character disorders are particularly difficult among alcoholics. This is in part due to the fact that Axis II diagnoses are not as devastating to the integrity of the personality, and therefore may be obfuscated by substance abuse. Alcohol intensifies the moroseness of a depressive and the anxiety of those with anxiety disorders. In a disorder, such as antisocial personality, drinking generally accompanies a behavior pattern that, in the absence of the personality disorder, could be attributed to the drinking alone. Rigorous criteria are required to document the existence of an antisocial personality [19] including, at a minimum, difficulty in at least four life areas, namely, problems with family, peers, school, and police, commencing before age sixteen. By these criteria, approximately 10-20% of male and 5-10% of female alcoholics suffer antisocial personality disorders. These individuals bear a more negative prognosis than those whose difficulty with the law is solely alcohol-related.

Public intoxication, belligerence, driving under the influence, and other alcohol-related crimes generally disappear upon cessation of drinking and are not part of an enduring pattern of antisocial behavior [19]. Because anxiety and insomnia may persist for three to six months following cessation of alcohol use, anxiolytics and hypnotics with any addicting properties should be avoided. This is done to avoid dependency and because anxiolytics and hypnotics seldom maintain effectiveness after two to four weeks, lending to abuse to maintain effect [19]. Nonmedical approaches such as no caffeine after 3 P.M., going to bed and arising at fixed times without any daytime napping regardless of how little sleep was achieved, and use of relaxation techniques such as meditation and self-hypnosis should be prescribed.

The distinction between alcoholic hallucinosis and paranoia and schizophrenia is particularly important. Schizophrenia has a decidedly worse outcome. Alcoholic paranoia and hallucinosis, on the other hand, frequently clears within days or months, regardless of treatment [19]. Embryopathy is greater among offspring of alcoholic than nonalcoholic mothers [53]. Many of the psychiatric disorders seen with alcohol use are the expected depression attendant upon use, which disappears upon cessation of drinking; the occurrence of specific alcohol-related psychiatric disorders such as delirium tremens and paranoia [54]; and what we perceive to be personality disorders [55,56].

Personality disorders may be partially conditioned by the need to secret alcohol as well as to deny alcoholism in order to maintain an amiable relationship at work and with family. Studies of families of alcoholics have failed to demonstrate increased risk for schizophrenia. Family members of schizophrenics are rarely alcoholic [19].

A number of provocative findings reported in the literature merit further investigation. One is that the level of an alcoholic proband's subjective anger is more closely associated with alcoholism than antisocial personality [31]. Another is the finding that while antisocial personality and substance use disorders are common psychopathologics among male alcoholics, major depression and phobias are common among female alcoholics [57-59]. In women, psychiatric disorders often appear to precede alcohol abuse or dependence. In men, however, with the exception of antisocial personality and panic disorder, psychopathology usually occurs subsequent to alcohol use. Other studies [60] indicated that phobias and non-confrontational personality disorders precede abuse of alcohol. Drinking tends to relieve the distress. For both men and women, alcoholism coupled with antisocial personality or drug abuse has a poor prognosis [61-63]. Major depression with alcoholism is associated with a better outcome.

Alcoholism and Organic Mental Syndromes

Concurrent psychiatric disorders and alcohol abuse are only part of the diagnostic dilemma of dual diagnosis and alcoholism. Chronic and sporadic excess alcohol drinking is associated with more physical problems than other substance abuse. Falls lead to subdural hematomas with organic mental syndromes; sudden cessation of use may result in delirium tremens with seizures. Indiscriminate hetero- and homosexual behavior at times of intoxication leads to AIDs and other sexually transmitted diseases, with their attendant psychiatric syndromes (e.g., AIDS dementia and delirium). Nerve cells die with chronic abuse, leading to alcoholic dementia and peripheral neuropathies mimicking hysterical paralysis. Neglect of diet leads to

Wernicke's encephalopathy and a host of other deficiency diseases associated with changes in mental status.

Chronic alcoholism is a potentially treatable cause of dementia [1,64]. Thiamine deficiency is etiologic in development of Korsakoff's psychosis, the chronic component of the Wernicke-Korsakoff syndrome. Amnesia with relative preservation of other cognitive functions is its most striking feature. Confabulation occurs early. Alcohol dementia, a more global syndrome than Korsakoff's, occurs on autopsy in about two-thirds of patients with alcohol changes in the brain. Cortical atrophy and reduced cerebral blood fluid are found. While end-stage dementia is unremittable, abstinence produces some resolution in less chronic cases if detected early [64]. Neuropsychological impairment appearing upon cessation of drinking becomes less pronounced with continued abstinence [66]. Early remission is attributed to reversal of cerebrospinal fluid acidosis, to other ionic imbalances, and to inhibition of brain protein synthesis. Changes occurring over a longer period include increases in dendritic arborization and glial tissue. As much as two years may be required for reversal of sleep disturbances and electroencephalographic abnormalities. Short-term memory, visual motor performance, and general intellectual functioning all improve [66]. In addition to the Wernicke-Korsakoff syndrome and alcohol dementia, an undetermined number of adult alcoholics suffer the residual form of the attention deficit hyperactivity disorder (ADHD). Some feel that the diagnostic criteria for Wernicke's encephalopathy (confusion, ophthalmoplegia, and ataxia) are too rigid, thereby missing a number who have the disease at necropsy who might have been successfully treated if the disease had been identified early. One of the criteria is absence of any other cause of dementia deemed sufficient for the diagnosis [66].

Seizures are a predictable occurrence with abrupt discontinuation of alcohol intake. Alcohol also lowers the seizure threshold for those with epilepsy. Nearly half of the seizures occur 13 to 24 hours after cessation of use [67]. Therefore, seizures in an alcoholic may be due to cessation of use just as they may be due to excess use of cocaine or amphetamines and *not* represent a separate diagnostic entity.

Alcohol and drug use per se do not lead to AIDS; sharing needles and careless sexual behavior under the influence do. Alcohol and other drugs, however, are known to inhibit the immune system and, therefore, may play a contributing role by impairing initial resistance to the virus. AIDS can present with insomnia, abulia, anhedonia, psychomotor retardation, dysmnesia, anorexia, weight loss, mania, command hallucinations and persecutory delusions mimicking schizophrenia, alcoholic paranoia, and affective illness [68]. The course may be quite prolonged with only subtle changes and may be masked by alcohol use.

Changes in blood pressure and in the heart lead to hypertension and congestive heart failure, both of which can mimic a number of anxiety disorders [69-71]. The Los Angeles Heart Study revealed mean blood pressure of heavy drinkers to be significantly higher than that of light drinkers and nondrinkers. In the Framingham study, rate of hypertension was twice that of nondrinkers [70]. Alcohol-induced blood pressure increase is one of the treatable causes of hypertension [71]. Level of gamma gluytamy/transference (GGPT), an enzyme particularly sensitive to ingestion of alcohol, is related to high blood pressure [72].

Alcohol-induced liver and bone diseases all produce illnesses that may compound the diagnoses of alcohol-induced mental changes [75,76]. Acute and chronic hepatic disease is associated with lethargy and depression.

DUAL DIAGNOSIS: DRUG USE/AFFECTIVE ILLNESS

Rates of major depressive disorder, scores on depression scales, and rates of self-reported suicide attempts increase progressively with increased use of licit (tobacco, alcohol, and psychotropics without prescription) and illicit substances [77]. A number of depressive scales have been evaluated for relative sensitivity and specificity in detecting depression in substance abusers. On the whole, sensitivity is good (65-94%). Specificity is less impressive (39-61%). Rounsaville et al. [62] have found the 13-item patient self-report the most specific and sensitive test for depression and recommend it for screening for depression in substance abusers. Substance abuse is a particular problem among young patients, particularly young adult chronic patients [78]. Persistent substance abusers have psychiatric hospitalization rates twice as high as patients who are former users or nonusers. Abuse of drugs, in fact, frequently precedes hospitalization. That these patients tend to deny use underscored need for urine and serum screens of all young adult chronic patients to identify and treat substance abuse and minimize readmission. Safer [78] reports that 45% of this subpopulation have been hospitalized three or more times; 60-73% are unemployed. More than 50% receive government assistance; 24-41% have adult criminal records; and 34-50% have documented substance abuse. The young adult chronic population is currently responsible for considerably more community problems than it was in the past. Young handicapped men as a group show more depression and alcohol- and drug-related problems than matched controls, highlighting need for particular care in assessment and treatment of this group [79].

Depression and/or substance abuse are commonly found in eating-disorder patients. Hatsukami and her group [40,41] evaluated 108 women who met DSM-III criteria for bulimia and found that 43.5% had a history of affective illness and 18.5% a history of alcohol or drug abuse. Approximately 56% of the bulimics scored within the moderate-to-severe range of depression on the Beck Depression Inventory. The relationship between affective and eating disorders is a concern of some controversy. On the one hand, it is clear that a significant number of patients with bulimia and/or anorexia respond to antidepressants. On the other hand, people who fear that they cannot achieve a body image to comport with their fantasized ideal may feel that they have reason to be depressed. That greater than one-half of patients with bulimia have been found to have positive dexamethasone suppression tests (DSTs), a rate comparable to that found in patients with major depression, along with the reported high incidence of affective illness in first-degree relatives, suggests a relationship between the two illnesses. Substance abuse in this group is not limited to alcohol and recreational drugs. Marijuana, cathartics, diuretics, and steroids are also abused. The subpopulation of bulimic patients with both substance abuse and affective disorder show a higher incidence of attempted suicide and more social problems [41].

Schizophrenics may have particularly bizarre patterns of substance abuse, given their disorganized thinking. In one study [80], it was found schizophrenics who abused drugs had an earlier age of onset than those who did not. Drugs may have been taken in response to the mounting stress of an incipient psychotic deterioration or may have precipitated it. Low intelligence and academic difficulties are also correlated with early onset and may also contribute to the apparent link between substance abuse and early onset.

Patients with borderline personality are another group at high risk for substance abuse. This group is more pathologic than nonborderline substance abusers, [81] showing more depression, poorer impulse control, impaired reality testing, and antisocial tendencies.

Medical problems compound the picture of any substance abuse disorder. This is particularly true of AIDS which, perforce, is higher in intravenous drug and other substance abusers as well as in patients who experiment with both drugs and sex. The manifestations of AIDS, both medically and psychiatrically, are as legend as those of tuberculosis and syphilis [82]. All organ systems may be impacted by drugs. Even the eyes may be a site of drug absorption or suffer neurologic or vascular damage due to specific drug effects [83-84].

While patients with major psychiatric disorders and substance abuse are in need of more intensive inpatient and outpatient treatment, they more frequently drop out of treatment [85,86]. Outpatient management for the 21-39% of patients with substance abuse disorders who have a concurrent diagnosis usually of a personality disorder, affective illness, or psychosis is particularly problematic [85]. These patients often demand irregular discharges from the hospital, present only partially committed to treatment, and are seen in emergency rooms after failure in standard treatment programs. High symptom level for other disorders is correlated with treatment failure in both outpatient and inpatient settings [85]. These factors have contributed to a therapeutic nihilism that has limited access of dually diagnosed patients to many treatment programs, creating an untested impression that nothing is available to treat this group successfully.

It is true that the patients with more severe psychiatric disorders evince lower levels of improvement [86]. Figures substantiating this fact, however, come from nonmedical programs or treatment centers where limited attention is paid to diagnostic-specific interventions for patients with concurrent DSM-III-R disorders. Traditional nonmedical treatment centers cannot handle such patients. A patient who is accepted and not treated for the concurrent diagnosis frequently fails to improve and is seen as "not committed to treatment." When these patients are included in studies of outcome of inpatient care, it appears that neither inpatient nor outpatient treatment works. Demonstrating differential treatment impact requires a structured medical inpatient program with treatment tailored to individual patient needs. This is especially true for an adolescent population, where patterns of use are less enduring and personality development is in a sufficiently formative stage to allow greater impact. There is, in fact, some evidence to suggest that the severity of psychiatric symptoms and poor treatment outcome is less highly correlated with adolescents than it is with adults.

DUAL DIAGNOSIS: DRUG USE/SCHIZOPHRENIA

Unusual drug use patterns are seen in schizophrenia. Disorganized and delusional thinking in this group contributes both to bizarre patterns of use as well as to less used routes of administration (e.g., eye, penis, vagina) [1,12]. Certain drugs enhance symptoms of the primary illness or may, in fact, perfectly simulate functional psychosis. Cocaine, amphetamines, and other stimulants create a paranoid psychosis in a clear sensorium that perfectly simulates paranoid disorder and paranoid schizophrenia. Phencyclidine (PCP), in fact, not only creates a paranoid psychosis but is also associated with considerable violence, which may be incorrectly attributed to the schizophrenia, enhancing the stigma associated with the disorder. Fortunately, while there is considerable experimentation among chronic psychiatric patients with stimulants, alcohol, marijuana, and hypnotic sedatives, only a small number actually use PCP [87]. Hallucinogens, on the other hand, do not create psychoses that truly simulate schizophrenia. Drugs like LSD, psilocybin ("mushrooms"), mescaline, and peyote ("cactus buttons") evoke chemical psychoses with characteristic hallucinogenic distortions of perception such as synesthesias (a condensation of two sensations); for instance, a person will "taste" green or "smell" gray. These symptoms suggest concurrent or sole use of a hallucinogenic drug when a patient presents psychotic. The picture in some patients remains sufficiently complex to render a number of LSD psychoses indistinguishable from acute schizophrenia. In one study of 52 LSD psychotics and 29 matched first-break schizophrenics [88], LSD patients did not differ in incidence of psychosis or suicide among the parents. Rate of parental alcoholism, among the parents of those with LSD psychosis, however, far exceeded that of controls and of the general population. While the two groups were distinguishable in some clinical parameters, they were equivalent in premorbid adjustment and by most cognitive measures when initially hospitalized or reassessed three to five years later. Both groups had the same rehospitalization rate.

Many believe that LSD alone does not produce an enduring psychosis but rather precipitates schizophrenia in predisposed personalities. There remains an uncertainty as to the relative role of monoaminergic pathways in schizophrenic illness. LSD is active in serotoninergic systems, and studies indicate serotoninergic aberrations in schizophrenia. Part of the confusion originates in the fact that when an already psychotic patient takes LSD, the preexistent psychosis may be misconstrued as induced. LSD use may have been an attempt either to self-medicate, to help give "insight," or to organize the external world when the internal world is chaotic. It may also simply represent poor judgment or superimposed character disorder, resulting in use of a drug that complicates the clinical picture and can lead to fatal behavior. People on LSD have assumed that they can fly, resulting in a death that may be construed as a suicide when, in fact, it is the result of the distorted thinking symptomatic of hallucinogen use. Incidence of psychiatric illness requiring hospitalization is increased in parents of patients with LSD psychosis [89]. Patients can be singularly inventive in their use of substances that induce psychosis as they seek "insight" or "psychotherapeutic progress." One patient was able to induce a schizophrenic-like psychosis by ingesting isosafrale after he failed to do so with amphetamines and LSD [90].

DUAL DIAGNOSIS AND COCAINE USE

Cocaine poses special problems in dual diagnosis, given the multiple routes of absorption and the various organ systems on which it impacts. Cocaine is absorbed rapidly from mucous membranes. Commonly taken nasally or via the lungs ("freebasing"), cocaine can also be absorbed through the conjunctiva of the eye, the mucous membranes of the mouth (freezing), the vagina, and the penile urethra. It also can be injected intravenously or subdermally ("skin popping"). This drug is associated with high bioavailability since there is no hepatic first-pass effect. Cocaine blocks neuronal uptake of norepinephrine and dopamine and reduces the concentration of serotonin. Release of norepinephrine and dopamine by neurons is facilitated, and tyrosine hydroxylase is activated. Tryptophan hydroxylase activity is inhibited. Net effect: decreased serotonin, dopamine, and norepinephrine turnover [91].

The most common concurrent psychiatric illness with cocaine abuse is affective illness. Depression is found significantly more often in patients using cocaine than among opiate and depressant abusers. Remarkably, incidence of affective disorder in first-degree relatives of cocaine abusers is also increased when compared to the other groups, suggesting that, in the dual-diagnosis patients, use of cocaine or crack may represent self-medication of an affective disorder. Early euphorogenic effects are attributed to increased dopamine and norepinephrine activity due to inhibited reuptake of these transmitter substances at presynaptic terminals. This effect is similar to that of some antidepressants and to amphetamines, which cause similar mood elevation in depressed patients. The effect is not sustained. In most patients, continued and increased use of cocaine leads to a worsening of depressive symptoms [92].

The particular psychopharmacologic effects and multiple routes of administration lead to many medical complications that can result in dual, triple, and more diagnostic problems. Myocardial ischemia [73], myocardial infarction [93] and cardiomyopathy, myocarditis, and malignant ventricular arrhythmias are among the most dreaded effects [94]. Risk for myocardial infarction is greatest among those with preexistent angina. Cocaine is arrhythmogenic, causing sinus tachycardia, ventricular premature contractions, ventricular tachycardia and fibrillation, and asystole. Cocaine also produces hyperpyrexia, leading to seizures and possibly arrthymias. Large amounts of cocaine can lead to marked increase in systemic arterial pressure and rupture of the ascending aorta [93].

Pulmonary complications include spontaneous pneumothorax when "pocket shot" is used by IV drug abusers seeking access to the internal jugular vein [95]. Freebasing has been reported to cause, or contribute to, asthma in those predisposed as a nonspecific irritant [96]. Necrosis with perforation of the nasal septum, atrophy of the nasal mucosa, loss of smell, lung damage, pulmonary edema, respiratory paralysis, and reduction in the capacity of the lungs to diffuse carbon monoxide are other respiratory complications [93].

Cerebrovascular accidents have been found temporally related to cocaine use. Subarachnoid hemorrhage has been reported within minutes of intranasal administration. Individuals with occult arteriovenous malformations are at particular risk. Cocaine users with headaches should be apprised of this risk. A common central nervous system effect is seizures. Cocaine lowers seizure threshold, with the result that a seizure may be caused by as little as a single dose. Cocaine-induced seizures should be considered a possibility in anyone presenting for the first time with epilepsy after age ten [93].

Other complications of cocaine use that may present concurrent use include intestinal ischemia with pain or frank gangrene in individuals who take cocaine orally or serve as "mules" or "body packers" by swallowing cocaine to get it through customs; complications of pregnancy (e.g., abruptio placentae, spontaneous abortion, congenital malformations, neurobehavioral impairment, perinatal mortality); severe lactic acidosis, especially in the sprint-trained athlete [97]; precipitation of acute porphyria [98]; spontaneous pneumomediastinum; and pneumopericardium [93]. Aberrations of glucose metabolism can lead to a number of behavioral changes that resemble those of cocaine use itself (e.g., aggressive and depressive behavior) and of other major psychiatric disorders (e.g., major depression). The changes in glucose levels may be due to neglect of diet seen in drug abusers and alcoholics, noncompliance with medication prescribed, and sensitization to epinephrine, which mobilizes blood glucose. Sexual dysfunction may antedate or follow cocaine use. Concerns over lack of sexual responsivity may result in seeking out cocaine as an aphrodisiac to enhance sexual performance. Sparing use can lead to increased sexuality and delayed ejaculation and orgasm-heightening pleasure. Prolonged use is generally correlated with diminished sexual performance and interest. Cocaine becomes the mistress or lover before whom all competitors fail.

DUAL DIAGNOSIS AND SOLVENT USE

Recreational use of inhalants and solvents for transient highs is correlated with preexistent psychopathology and can induce a number of neuropsychiatric and physical complications, obfuscating the underlying primary pathology. Deliberate inhalation of metallic paints, for instance, leads to hemorrhagic alveolitis [99]. Despite severe and predictable harm to the body from this practice, chronic solvent abusers' response to substance abuse treatment is poor, perhaps because those who abuse solvents over protracted periods of time have behavioral patterns that militate against good social adjustment and positive treatment response. Long-term inhalation of paint thinners, aerosols, gasoline, and cleaning fluids (generally from solvent-soaked rags in plastic bags) leads to some euphoria and disinhibition. Auditory and visual hallucinations occur, coupled with ataxia and tinnitus. The effect wears off in 30–45 minutes as the patient falls asleep with impaired memory of the event [100]. Medical complications include cerebellar toxicity, potentially irreversible encephalopathy, renal dysfunction, cardiac irritability, generalized weakness, and abdominal pain.

Solvent abusers tend to be adolescents. Only a small fraction experiment beyond a few times. Any inhalation of solvents that may lead to permanent damage is distressing. Chronic use entails development of permanent maladapture characteristics in the developing personality in childhood and adolescence. Solvent abusers as a group are more depressed than those who do not abuse solvents [101]. Solvent abusers also more frequently abuse alcohol. Chronic use for some is on the trajectory to heroin addiction. Shoplifting, truancy, and problems in school have been found to coexist with solvent abuse [100]. Lead tetraethyl (the antiknock agent in gasoline) creates a short-term psychosis characterized by hallucinations, mania, fear, and schizophreniform symptoms [102]. These isolated periods of psychosis resemble the micropsychotic episodes of borderline patients and may be misconstrued as such. Obviously, in some instances, the abuse may be symptomatic of a borderline or antisocial personality. One may, in fact, question whether what becomes a borderline personality is, in some cases, the outcome of a multiple substance-abusing episode at a time when the identity is evolving. The adult identity has elements of psychosis that are derived from aberrations of thought and effects of substance abuse.

DUAL DIAGNOSIS AND BENZODIAZEPINE USE

Benzodiazepines are used by depressed, eating-disordered, and manic patients. Abuse may be intentional to obtain relief or iatry. In the latter instance, anxiotolytics and soporifics have been prescribed for anxiety or panic accompanying a depression or eating disorder or to induce sleep in insomniac depressives and hypomanic and manic patients. With progression of the mood or eating disorder, more is required to achieve the same effect because of either habituation or progressively increasing intensity of symptoms. Eventually, patients are addicted. Any reduction in dosage is fraught with discomfort. Increased doses are required for relief. Intermittent intoxication and withdrawal results in an oneiroid state mimicking schizophrenia. The primary use of benzodiazepines is the management of anxiety and panic with the exception of alprazolam, which also appears to be useful in the management of some depressions.

Despite widespread use of benzodiazepines for anxiety disorders and depression, it is remarkable that many do not become addicted [103]. Dependence occurs at remarkably low doses [104], to the surprise and dismay of patients and physicians alike. Long-term therapeutic use of even small doses can lead to remarkable dependence (so-called low-dose dependence), requiring considerable skill in both management and withdrawal. Symptoms of withdrawal or intoxication are often confused with those of primary anxiety or mood disorder.

DUAL DIAGNOSIS AND PSYCHOSTIMULANTS

Psychostimulants are commonly abused by psychiatric patients. The most commonly abused, cocaine, has already been discussed. Less commonly used but equally potent in their impact are dextroamphetamine and methylphenidate. These typically cause manic-type highs, the anxiety symptoms of a racing heartbeat, and palpitations. Frank paranoia and profound depression on cessation of use ("crashing") is also seen. Concurrent use of cocaine and amphetamines often occurs. Use of stimulants contributes to relapses in schizophrenia. Short-term use alone of moderately large doses of stimulants without dormant schizophrenia can induce acute paranoid psychosis [105]. These psychoses are usually of brief duration, remitting rapidly upon cessation of stimulant use. There is some question as to whether the facility with which psychoses may be generated relates to the degree psychosis lies dormant in the user.

Stimulant psychoses, more than hallucinogenic psychoses, resemble psychogenic psychoses, particularly paranoid schizophrenia. Paranoia occurs in a clear sensorium with ideas of reference and at times auditory hallucinations. It differs in that delusions tend to be less well developed with stimulant use and stereotopics are more frequent with stimulants. Neuroleptic response is the same for both. Only the fact that the paranoid psychosis passes with cessation of stimulant use is helpful. In addition to causing paranoid psychosis, stimulants intensify or exacerbate symptoms in someone already schizophrenic or manic.

DUAL DIAGNOSIS AND PSYCHOTROPIC ABUSE

Psychotropic drugs such as thioridazine, doxepin, amitriptyline, and anti-Parkinson drugs, which are sold on the street, to attenuate or qualitatively impact on the character of sensory change with substance abuse. For instance, anti-Parkinson drugs are abused to achieve a euphoric state, for stimulant effect, as hallucinogenics, and for social stimulation [106]. Effect is dose-dependent. Higher doses than that required to manage extrapyramidal side effects are required. Trihexylphidyl has particularly great abuse potential. Termination of anti-Parkinson drugs may lead to premature termination of treatment because of unpleasant symptoms independent of motor problems.

LABORATORY STUDIES

The dexamethasone suppression test (DST) has been employed to support the diagnosis of depression. Of patients with major depression, 45–50% fail to suppress cortisol after being given a 1-mg oral dose of dexamethasone at 11 P.M. Diagnostic sensitivity varies depending on blood collection times, laboratory accuracy, dexamethasone dosages given, and diagnostic criteria. Numerous medical conditions impact on its validity and reliability, making its use particularly problematic with dually diagnosed patients. Drugs specifically influence the dexamethasone metabolism via liver enzyme alterations. Burch et al. [107] found, in a study of 336 psychotic inpatients, that 60% were taking one or more drugs that changed the DST results in either a false-positive or false-negative manner. Fluctuations in neurotransmitter production affects hypothalamic-pituitary-cortisol feedback mechanisms, altering DST outcome. False-positive results may be found with sedative hypnotics, alcohol, and narcotics. False negatives occur with benzodiazepines and stimulants such as cocaine and amphetamines [107]. Marijuana can cause both false positives and false negatives. Withdrawal phenomena and liver abnormalities altering catabolism of steroids may be responsible for abnormal DSTs during the first two weeks of abstinence. The response with continued abstinence resembles that of normal controls. Nonsuppression of cortisol secretion, coupled with clinical signs of depression, suggests need for a trial of antidepressants or electroshock [108]. Modest hepatic dysfunction does not appear to invalidate DST results [109]. Chronic alcoholism impacts the hypothalamic-pituitary-adrenal axis preventing the cortisol hypersecretion often seen with depression. That this is not always so is indicated by a number of studies showing nonsuppression in a significant number of alcoholics reporting depression [35,36].

The thyrotropin-releasing hormone (TRH) test, which also is abnormal in some patients with depression, is not specific for major depression with cocaine abuse [35,36]. There is evidence that cocaine is associated with blunted results on TRH testing in much the same way that dopamine infusions in humans cause a blunted TRH response. In alcoholics, TRH abnormalities may be due to the fact that chronic alcoholism causes both endocrine abnormalities and hepatic dysfunction.

PSYCHOTHERAPY WITH DUALLY DIAGNOSED PATIENTS

Group techniques, particularly 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous, are a critical component of substance abuse treatment. For the compliant without a coexistent psychiatric disorder, it may be all that is necessary. When a primary psychiatric illness exists, the attending psychiatrist must be aware of the philosophy of AA, NA, and CA (Cocaine Anonymous) and of the need for concurrent involvement of the patient in these groups. Family members and lovers should be encouraged to attend Nar-Con and Al-Anon. A therapeutic alliance is necessary to assure that patients continue psychopharmacotherapy as prescribed as well as abstinence and involvement in a 12-step program. Therapists should take both an active educational and confrontational role [110]. The clinician's understanding of the pharmacology and pattern of use of substances abused is necessary to achieve continued abstinence and appropriate pharmacotherapy as well as to maintain credibility and respect with users and their families.

CONCLUSION

In conclusion, it is uncommon today to see any one drug used alone, including alcohol. Polysubstance abuse is more usual. Identification of preexistent or concurrent psychiatric disorders is complicated by the myriad of psychiatric symptoms caused by drug use and by the medical conditions it induces. While a panic attack may be due to the tachycardia and chest pain attendant on cocaine use, the correct identification of true panic disorder leading to substance abuse can lead to diagnostic-specific treatment. Treatment of nonsubstance abuse psychiatric disorder is more effective than treatment of pure substance abuse. In addition, the reported rates of suicide in untreated major depression (15%) and panic disorder (18%) [111] suggest that not only may dually diagnosed patients be self-medicating depression or panic but may also be indulging in a self-destructive behavior that predictably is a consequence of the untreated course of their illness.

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Issues in Managing an Alcoholism Caseload

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The issues involved in managing a caseload with persons who are substance abusers are many, and can be stumbling blocks for effective work by the rehabilitation counselor. This article identifies four areas of concern (counselor issues, family issues, employment issues, and client issues) that may assist the counselor in the evaluation of personal and professional responses. Additionally, some practical suggestions are offered.

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Alcoholism is a disease that crosses all social, economic, ethnic, racial, and geographical lines. Estimates on its prevalence in the United States vary from 4% of those eighteen years and older to 10% of the males and 5% of the females eighteen years and older (Gallant, 1987). A 1978 Gallup Poll asked the question, "Has liquor ever been a cause of trouble in your family?" and 24% of those queried responded positively (Apthorp, 1985). There can be little doubt that rehabilitation counselors will encounter persons who have this disease. Whether counselors have a general caseload to manage, or a specialized caseload of clients whose disability is alcoholism, there are certain issues related to alcoholism that must be addressed for effective case management.

Such issues may be divided into four general areas, as illustrated by Figure One. First, there are issues concerning a counselor's personal experience with the disease and the subsequent perceptions and reactions to persons with the disease. Second, the disease of alcoholism affects all family members. The involvement of the client's family members in the disease process and in the rehabilitation process will be a source of issues to be evaluated. Third, alcoholism entails issues affecting the client's employment history (e.g., multiple positions, unfocused future, and lack of acceptable work habits). Finally, there are issues specifically relating to the client. These relate to the chronic,

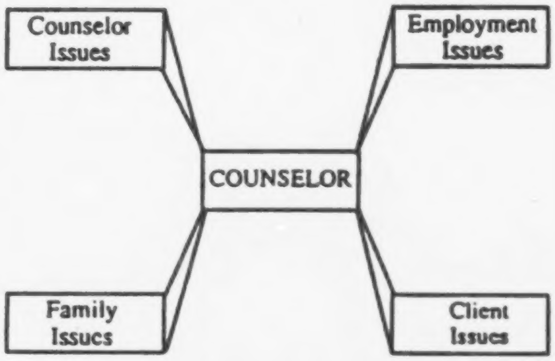

Figure 1. Interplay of alcohol abuse caseload issues

progressive and potentially fatal nature of the disease of alcoholism.

Counselor Issues

The first area of discussion focuses on issues arising from the counselor's personal experience with the disease. One of the realities about alcoholism is that it is characterized by highly charged emotional undercurrents—everyone has an opinion. These undercurrents may manifest themselves in both personal and social ways.

The counselor should begin by looking to his or her own experience with alcohol and alcoholism. This personal evaluation can begin with some basic questions. Did the counselor grow up in a home where one or both parents were alcoholic? Is the counselor married to an alcoholic? Does the counselor have reason to be concerned about her or his own use of alcohol? Is the counselor a recovering alcoholic? Is the counselor currently abusing alcohol? Affirmative answers to any of the above questions should be warning flags for the counselor. The counselor's effectiveness with clients with alcoholism may be determined by a personal experience with the disease. This same awareness also applies to counselors who grew up in a dysfunctional family of any description. The estimates are that one in three helping professionals are adult children of alcoholics, because helping others is an easy and natural role for adult children. These persons had family roles of care-takers from an early age, and it was an easy transition to teaching and helping professions (Anonymous, 1988).

It is possible to believe that a person should be knowledgeable about working with persons with alcoholism, because they grew up in a home where alcoholism was present. As with so many factors related to alcoholism, the obvious and logical cannot be taken for granted because of the dysfunctional thinking that grows out of the dysfunctional family system. In some ways the least effective counselor, whether an alcoholic or the adult child of an alcoholic, is the one who has not acknowledged and dealt with a personal history with alcoholism. Anonymous (1988) warned that "our early experiences in alcoholic homes may have caused us to develop attitudes and to exhibit behaviors that actually impede the work of the school [or rehabilitation agency] in substance abuse prevention and recovery (p. 22)." It is easy for the counselor to become a *professional enabler*, making it possible for clients and colleagues to avoid the consequences of their addictions (Anonymous, 1988). If a counselor is to work effectively with clients who are alcohol abusers, then that counselor must come to terms with personal and family history.

There are numerous community and learning resources available for persons with a personal or family history of alcoholism. The most well-known programs are Alcoholics Anonymous and its derivatives (e.g., Narcotics Anonymous, Al-Anon, Nar-Anon, ACOA/ACA (Adult Children of Alcoholics), CoDA (Codependents Anonymous)). Information about these Twelve Step programs and meeting times and locations are available through the local AA Hotline (the number can be found in the telephone directory).

There are a number of excellent books available about alcoholism, chemical dependency, and the many variables involved. The writings by Janet Woititz (*Adult Children of Alcoholics, Home Away From Home*), Claudia Black (*It Will Never Happen To Me!*), Sharon Wegscheider-Cruse (*Choice-Making*), Melody Beattie (*Codependent No More*), Earnie Larsen (*Stage II Recovery: Life Beyond Addiction*), Vernon Johnson (*I'll Quit Tomorrow*), George Vaillant (*The Natural History of Alcoholism*), a Donald Gallant (*Alcoholism: A Guide to Diagnosis, Interve tion, and Treatment*) are all excellent beginning points.

There are primary treatment programs (inpatient, outpatient, and residential) for alcohol and drugs, co-dependency, eating disorders, adult children of an alcoholic and dysfunctional family. Information about alcohol and drug treatment centers may be obtained by calling the different centers in one's area. These treatment centers, whether freestanding or connected with medical centers, will be listed in the telephone book. Again, the local AA Hotline can be a valuable resource for treatment center information.

Opinions about alcoholism are also expressed in a social setting also. It is only within the last generation that the American Medical Association has recognized alcoholism as a disease. In the collective understanding of American culture, alcoholism previously was seen as a moral weakness. This perception lingers today in more subtle ways. It is not unusual to hear statements like, "I really don't like those alcoholic people. They should do something about their drinking."

One of the perceptions of alcoholism that is common in society is that the person who is alcohol dependent is *morally weak*. Alcoholism is seen also as *willful misconduct* by some persons, institutions, and organizations. "Alcoholism, [is] a medically accepted definition that carries no moral judgments. To that end, we can be most effective if we understand alcoh ism to be a primary, progressive, chronic, and fatal disease... *coholism is not a symptom of a more serious problem* (Apthorp, 1985, p. 57)."

The consequences of such a perception of alcoholism result in marginal treatment opportunities, limited support of the client who is in recovery, and denial of the magnitude of the disease's power over the client's life—past, present and future. It is also a pessimistic view for ultimate recovery through treatment and rehabilitation. To hold such a position is not unlike saying that the person with diabetes or cancer has developed their disease because they chose to do so. The surest cure for such a perception of the disease is continuing and continual education on alcoholism and drug addiction, both for counselor and the community.

Family Issues

The second area of discussion includes issues related to families. Alcoholism does not exist within a vacuum, for it is a disease shared by the whole family. It is often described as a family disease. The type and extent of family members' involvement in the rehabilitation process will have definite effects on the way the counselor manages the case. Good family involvement is essential for successful rehabilitation. As with persons with other types of disabilities, the person who is an alcoholi will have family involvement across the full spectrum rangi from total rejection to overprotection and enabling manipulation.

One extreme of familial *presence* is alienation, rejection, or being disowned by one's family. The resulting sense of isolation and disconnectedness feeds the poor self-esteem that is often part of the client's psyche. Another expression is the family member or members who encourage alcohol abuse out of their own sickness. This arises when family members are alcohol abusers themselves, from a pathological need to maintain control, or from the multiple dynamics of codependency. Gallant (1987) maintains that:

> *Although there is no consistent family system or psychologic pattern that develops within families of alcoholics, the therapist working with alcoholics should be aware of a number of maladaptive behavioral patterns common to such families. The alcoholic has a profound effect on family members and other individuals closely associated with the family. Psychologic reactions to the alcoholic can vary considerably among family members, depending partially on the alcoholic's behavior while sober as well as drinking and partially on the family member's psychological state.* (p. 199).

The client's rehabilitation can easily be sabotaged by a family member determined to maintain a familiar family system. It even may be a wildly dysfunctional family system but it is one that is known. The operative principle is that known unhealthy behavior is better than unknown health. A family system naturally seeks the *homeostasis*, the balance, regardless of dysfunctional expression in order to reestablish a sense of peace in the family. This sense of familial peace is often false, unhealthy, and temporary, but in the dysfunctional perception of the family it is seen as *normal.*

The counselor's awareness of such actions by the client or client's family is essential. Awareness and action by the counselor may avert a situation that jeopardizes the rehabilitation plan and goals, and may lead to a loss of sobriety. In many ways, this is the most difficult area for the counselor because it is the one over which the counselor has little or no control. There are families who clearly are the greatest threat to the client's sobriety, recovery, and rehabilitation.

How does the counselor deal with such a situation? There is no easy or standard answer for this problem. The counselor may find that the client can best be served by leaving the home environment, and entering a half-way house. Referral to community mental health agencies, child and family services, private social service agencies, or private mental health providers may be the most effective path to follow. Here the counselor's developed network of community resources can come into play for the client's benefit.

Employment Issues

The third general area of discussion concerns issues revolving around the client's employment history, such as multiple positions, unfocused vocational future, and lack of acceptable work habits. Issues in this area relate to past, present and future employment obstacles. Employment and alcohol have a symbiotic relationship. Employment is often necessary to obtain the money to purchase alcohol, and alcohol significantly affects productivity in the economy.

Employee Assistance Programs (EAPs) came about in the 1940s in response to the needs of recovering alcoholics, who "returned to past employers and said, 'If you hadn't been so nice to us, we might not have lost our jobs and families. We know there are many other alcoholics in the workplace—will you let us start a program?'" (Watts, 1988, p. 11). EAP consultant Dale Masi found that, on average, public agency supervisors covered up for twelve years and private-sector supervisors for up to eight years for problem drinker employees. "It's much easier to close your eyes to problem employees, demote them, promote them, or put them on detail work." (Watts, 1988, p. 11). In the job development and placement portion of rehabilitation, the potential exists for finding employers who will be enablers of the client's disease by avoiding the *tough love* decisions that become part of recovery. Employers may be alcohol abusers themselves, and do not consider alcoholism a disease. This places the client in an environment that jeopardizes sobriety.

It is not unusual for a client, whose disability is alcohol abuse, to have a voluminous work history. The recovering alcoholic who has a career or a profession to return to after treatment is not often a client for public rehabilitation services. The type of client that the counselor normally encounters is an individual who has had multiple jobs in varied fields, but rarely for an extended period of time. They often have been terminated because of drinking. The typical client has a limited sense of their vocational future because little or nothing has happened to encourage forward thinking on these issues.

One of the clear strengths of rehabilitation counseling is its routine use of vocational assessment. A client with a *spotty* work history can well be served by vocational evaluation. This could include not only such factors as interest inventories, intelligent tests, and achievement tests, but also the person-to-person interview. This evaluation process should not begin until the client is well into treatment, and is drug-free.

Counselors also must face the need for adjustment in client work habits. Interwoven within the client's poor work habits are recurring events of conflict with the boss and other persons in positions of authority. Absenteeism or *laying out* are undesirable traits, that are often a typical part of a client's work history because of the physiological effects of alcohol abuse. The client's referral to a work adjustment program may be an essential ingredient of a total rehabilitation plan. The counselor will have to determine the timing of training and adjustment according to local resources. Specialists in job placement and development can be an invaluable resource at this portion of the rehabilitation process.

Client Issues

The fourth area of discussion concerns issues that specifically revolve around the client. Once it was thought that someone was an *ex-alcoholic* or a *recovered* alcoholic as if there was a cure for the disease. However, the counselor needs to always remember that there is no known cure for the disease, and that a client will never become an ex but will always be *recovering*. The single most important goal for the client is to maintain sobriety by not doing things that would jeopardize recovery.

One of the important ways that the counselor may benefit the client is to understand the patterns of alcohol abuse that the client followed. Knowledge of this may provide necessary warning flags of possible relapse. The disease process and symptoms were defined by E. M. Jellinek (1942, 1960) as having three stages. Stage I is the Early Stage in which alcohol is consumed socially (use). Stage II is the Middle Stage when a person

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becomes a problem drinker (misuse). Stage III is the Late Stage in which a person is dependent on alcohol (abuse). Another descriptive pattern maintains that there is a five-stage process leading to chemical dependency: (1) experimental use; (2) social use; (3) habitual use; (4) abuse; and (5) addiction.

Those reaching the final stage, the alcohol abuse client, are often children of an alcoholic home. They left a dysfunctional home and moved into or created one that was equally dysfunctional. This familial unhealthy environment has provided clients with skills to survive in *craziness* but not in health. Such clients often will have great difficulty appropriately expressing emotions and feelings. Such clients may have their feelings so tightly under control that they truly do believe that they feel okay. They have a poor self-image, and their self-esteem will need constant attention. Further, clients will often prefer to be in the *safety* of the known past or self-structured fantasy of the future. It is often less painful to avoid the realities of the present. This is particularly characterized by denial of a problem. The significance of denial in the disease process of alcoholism is such that it is seen as one of the definitive symptoms. The counselor may be one who will assist the client in staying in the present, confronting client denial, and dealing with the realities of rehabilitation.

The physical deterioration that comes from chronic alcohol abuse could present additional complications for the counselor, particularly if the client enters rehabilitation in later stages of the disease. Counselor knowledge of the significance of relapse on the physical condition of the client is essential. The client who starts to drink again will not return to a pre-drinking stage, but will begin at the point where he or she was before the period of abstinence. There may be accelerated physical and mental deterioration with death an ever-increasing possibility. The physiological processes are unrelenting in their potential for deterioration. This, if for no other reason, should merit the counselor's attention to the dangers of relapse. Relapse is an ever-present danger for a client, particularly during the first months of sobriety, but there are community programs available to support the client.

Considering the emphasis that is placed on the Twelve Steps of Alcoholics Anonymous in alcohol and drug treatment units, and the success of the program of Alcoholics Anonymous, it is appropriate for the counselor to be familiar with the Twelve Steps. The two books that contain essential information on Alcoholics Anonymous (A.A.) and on the Twelve Steps are *Alcoholics Anonymous* (1976) and *Twelve Steps and Twelve Traditions* (1981). As stated above, additional information on AA and access to its many resources are available through the AA Hotline (see the local telephone directory). Though a person cannot be forced to be involved in AA, the client would well be served by participation. The AA Twelve Step program is the one that succeeds where others have failed.

Summary

To be effective in the management of a specialized alcohol abuse caseload, or to be effective with alcohol abuse clients in a generalized caseload, the counselor can benefit from viewing the issues in four areas.

Counselor issues— how the disease may have affected the counselor in the past or is affecting the counselor in the present.

Family issues— alcoholism is a family disease so the counselor needs to be attentive to familial interplay and its effect on the client.

Employment issues— often the client will not have a goc work history, will have poor work habits, and the counselor w have to work diligently in the development of the rehabilitatio program.

Client issues— the alcohol abuse client will come with a variety of inappropriate, immature, or unhealthy emotional patterns or responses, and the counselor will be part of the client's learning new and healthy ways to cope with daily living and in gainful employment.

Suggestions for Successful Rehabilitation

1. Require the client to make a commitment to abstain from all non-prescribed mood-altering drugs.
2. Have the client participate in an on-going treatment and recovery program (e.g., inpatient or outpatient treatment at an alcohol and drug treatment center, AA meetings, Continuing Care/Aftercare after primary treatment).
3. Involve the client's family at all levels of the rehabilitation process.
4. Have the client develop a social system supportive of recovery (e.g., family, friends, other persons in recovery, employer, shop steward).
5. Have the client make a commitment to a daily structure that supports recovery.
6. Encourage the client to continue learning about the diseas
7. Encourage the client to look beyond self for the means an strength to continue in recovery— in the tradition of Alcoholics Anonymous, this is one's self-defined Higher Power.
8. Develop clear expectations and consequences with the client regarding renewed use. Follow through on the consequences.
9. Develop clear expectations and consequences with the client's employer regarding renewed use. Follow through on the consequences.

Working with persons with alcoholism can be exciting, rewarding, and frustrating all at the same time. There will rarely be a dull moment in dealing with the myriad of issues arising from an alcoholism caseload.

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Substance Abuse among General Psychiatric Patients: Place of Presentation, Diagnosis, and Treatment

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ABSTRACT

This paper reviews the literature on patients presenting for general psychiatric treatment who are also substance abusers. Place of presentation, diagnosis, and treatment are considered. A considerable portion of patients seen in emergency rooms, as much as half in some settings, are substance abusers, and over a third of general psychiatry admissions have been found to have their presenting problems materially influenced or precipitated by substance abuse. Substance abuse is also frequently found among psychiatric inpatients. Diagnostically, the differentiation of general psychiatric and addictive syndromes can be difficult: primary and secondary affective disorder from consequences of long-term substance abuse; and self-medication patterns from primary general psychiatric syndromes. Treatment studies are often focused on concomitant psychotherapeutic management for patient being treated for addiction. Often, emphasis is placed on pharmacotherapy for enhancing outcome in the dually diagnosed. Qualitatively, new options tailored to this population still remain to be studied, however, as do the changes necessary in the treatment system to assure proper long-term management.

INTRODUCTION

Relatively little information is available on the proper treatment of substance abuse in patients who present with other psychiatric problems. Despite this, there is a growing recognition among clinicians that patients treated for nonaddictive psychiatric illness often have their rehabilitation compromised by alcohol or drug abuse [1]. Although treatment facilities are generally segregated into separate units for general psychiatric disorders and substance abuse, it is becoming increasingly clear that many general psychiatric patients require coordinated treatment for combined disorders.

This article addresses the problem of patients with acute psychiatric presentations who present in general psychiatric facilities, and who additionally have primary or secondary addictive illness. These patients come to the attention of treating parties as they enter the mental health "portal" of the health system, and are distinguished from the patients who come through the addiction treatment "portal," for alcohol and drug problems, and are then found also to have psychiatric disorders. The problems of patients coming through the addiction portal have been addressed elsewhere, as in reviews by Meyer [2] and Gottheil [3].

PLACE OF PRESENTATION

There are no data available for the prevalence in the general population of combined general psychiatric and substance abuse disorders. The most exciting and most recent assessment of the prevalence of psychiatric disorders in the population overall is the Epidemiologic Catchment Area study, carried out in three metropolitan areas in 1980-82, where the following 6-month prevalence rates were found, on average [4]. Altogether, alcohol and drug abuse were found in 6.4% of the population (5.0% for alcohol and 2.0% for drug abuse, respectively). Comparable figures for schizophrenia and for affective disorders were 1 and 5.2%, respectively. Not surprisingly, substance abusers, characterized by denial of their illness, were poor consumers of treatment services. Only 1 in 7 (13.6%) was likely to have made mental health visits during the previous 6 months, whereas almost half (46.7%) of those with schizophrenia and a third (31.4%) with affective disorder (31.4%) had been seen during the same period.

As we shall see, patients with schizophrenia and affective disorders constitute a sizable portion of all persons treated in the mental health system who have difficulties with substance abuse. In order to ascertain the magnitude of the dual diagnosis problem, the presentation of such patients, as reported in the literature, will be considered in several different settings: the emergency room, the general hospital psychiatric unit, the Veterans Hospital, the public psychiatric facility, and the private psychiatric hospital. Because patients present differently in each of these settings, each is instructive with regard to the manifestations of the syndrome of dual diagnosis.

The Emergency Room

Of the wide range of patients who present in the emergency rooms (ER) of general hospitals, only a minority are admitted to inpatient services for acute care. In order to ascertain the fate of alcoholics in this group, Schwartz and Fjeld [5] followed the routing of alcoholic patients who presented at an emergency room in a large public general hospital by examining clinicians' evaluations of a series of alcoholic patients (N = 305). Half (49%) of these alcoholics were sent home from the ER, with or without clinic referral. Of the 39% who were admitted, one-third were sent into regular psychiatric units, having presented with acute problems meriting their care in an acute psychiatric unit. These latter patients were more often Black, probably, the authors speculate, because Blacks were more likely to treat their psychoses with alcohol rather than seek traditional psychiatric care. In a similar study of consecutive emergency cases (N = 174), Treier and Levy [6] found, using patient self-reports, that fully 35% of their sample had alcohol-related and 15% drug-related admissions.

In a more detailed evaluation, Atkinson [7] had house officers complete a research questionnaire on 503 patients seen in a psychiatry emergency service, so that each patient was evaluated to ascertain the importance of alcohol and drug abuse in his admission. Some measure of substance abuse was found relevant to precipitating the presentation in over half of the cases, with alcohol alone in 20%, drugs alone in 21%, and both together in 12% of the admissions. When cases were reviewed by diagnosis, it was found that alcohol or drug use played a role among 53% of transient situational disorders, 29% of schizophrenics, and 20% of affective disorders.

The studies noted here drew on either clinician assessment or patient report. None was based on data from urinalyses for drugs of abuse, although this technique has recently been found to be a valuable diagnostic tool, as will be subsequently seen. Nonetheless, even without such verification, it is amply clear from these findings that the emergency service is an important site for case-finding with regard to combined psychiatric and addictive disorders. If there were hospital-based services specifically designated for such problems, it is likely that a good number of emergency patients would be referred there.

The Psychiatric Acute Inpatient Service

The most severely disordered of psychiatric patients generally begin their care with admission to general hospital psychiatric units. How often is this course necessitated by circumstances related to alcohol and drug use? Crowley *et al.* [8] carefully evaluated 50 consecutive patients admitted to an adult psychiatric ward making use of clinical assessments, psychometric measures, and serum and urine analyses for drugs of abuse. By these means they found that 18% of these admissions would probably not have entered the hospital if not for a drug or alcohol problem, and an equal number had a substance abuse problem that contributed substantially to their admission. Both these groups were more likely to be diagnosed as character disorders than the balance of the patients, whose admissions were unrelated to drugs.

Urinalyses were positive for sedatives most frequently (24%), followed by alcohol (10%), narcotics (6%), and antipsychotics (3%). (It should be noted that the study was done in the early 1970s, and predated the recent rise in cocaine abuse.) Importantly, urinalyses revealed that the patients themselves often did not report the nature of their current drug use to interviewing physicians, underlining the importance of multiple sources of information.

Profiles on the Minnesota Multiphasic Personality Inventory suggested less psychosis and more sociopathy among the drug/alcohol-precipitated group of admissions. These patients apparently manifested less severe ancillary pathology than the other admissions, and were apparently hospitalized for drug-related symptoms primarily. Indeed, the authors point out that the alcohol/drug group had originally aimed to remedy their own difficulties, such as dysphoria and marital problems through intoxication, but these intoxicants were now more the cause of such problems than a result.

The findings of this study are complemented by those of two others. Ritzler *et al.* [9] found that patients in a psychiatric inpatient service with more acutely debilitating diagnoses, such as schizophrenia and other psychoses, were less likely to be heavy drinkers than patients with diagnoses of personality disorder or neurosis. In addition, the issue of social problems associated with substance use among patients on psychiatric services were examined by Davis [10], who used standardized interview schedules after admission to study a population of psychiatric inpatients ($N = 170$) and outpatients ($N = 130$). He found that 63% of the males and 49% of the females had a history of heavy use of alcohol or drugs, although these findings were not generally apparent in admission histories or hospital notes. Over half of the patients who used substances heavily (65% of the males and 45% of the females) experienced deleterious social consequences from their use.

It is difficult to differentiate whether social problems are a cause of drug abuse or a sequela. For example, Westermeyer and Walzer [11] studied patients ($N = 100$) between the ages of 15 and 25 who were admitted to the psychiatric unit at the University of Minnesota Hospitals, and defined 39% of them as heavy drug users. In comparison to other admissions, these patients were more often unemployed, divorced, or separated. They had experienced more problematic social events, such as felonies or truancy, and had more impaired social resources, such as family discord. The authors point out, however, that in some cases the problematic social behavior predated drug use and in others it followed it.

Altogether, these findings strongly suggest that substance abuse plays a prominent role in precipitating the admissions of a large portion of patients in acute psychiatric services, perhaps a third. Furthermore, relevant patterns of drug use are not necessarily ascertained in clinical interviews at the time of admission, and are generally not picked up in the hospital unless intoxication or withdrawal characterize patients' presentations.

Veterans Hospitals

Veterans Administration Hospitals house a population at considerable risk for substance abuse. Many veterans abused alcohol or drugs while in the military service, and subsequently found that the opportunity existed for continuing substance abuse while they were hospitalized at VA facilities. McLellan *et al.* [12], for example, found that half (49%) of a sample of VA patients (N = 156) hospitalized for psychiatric problems acknowledged that alcohol or drug use had been a "problem" for them at some points. These patients were more likely to have used *drugs* than alcohol if they had been hospitalized *during* the Vietnam era, and more likely to have had a problem with alcohol if hospitalized before. Importantly, almost a third (30%) of the overall sample indicated that they had used alcohol or drugs at least 3 times weekly during their stay in the hospital, therein reflecting the considerable access of patients to substances of abuse in this typical veterans facility.

Alterman and associates conducted a number of studies on substance use and abuse in Veterans Hospitals [13-15]. We shall consider their findings in relation to alcohol first. With the aid of nursing staff on nonsubstance abuse wards, they were able to identify 9.5% of schizophrenics among hospitalized patients (101 of 1,063) who carried a secondary diagnosis of alcoholism [13]. Of this group most (55%) were reported to be drinking during their hospitalization, and almost half of them (46% of the total) were known to become intoxicated. In addition, half were seen to have drinking-related problems interfering in their treatment (47%) and management (53%) in the hospital. Problem drinkers tended to be younger, more likely Black, and more likely paranoid than the remainder of the schizophrenic population.

In another study, Alterman *et al.* [14] evaluated general psychiatric patients in a VA psychiatric hospital (N = 979) and excluded those on designated substance abuse units. Altogether one-quarter carried a primary (11%) alcohol-related diagnosis (ARD) or a secondary or tertiary (13%) one. Altogether, 9% of the patients were reported to be drinking in the hospital although, interestingly, most of the drinkers came from the sizable group of patients who carried neither primary, secondary, or tertiary ARD. The authors point out that patients' drinking in the hospital seriously compounded their psychiatric problems, and was likely to yield a much poorer treatment prognosis.

Alterman *et al.* [15] also examined drug problems in the VA in another study, using reports by nursing staff. Altogether 40% of patients (N = 533) on acute and subacute psychiatric units had a history of alcohol abuse, and an additional 18% had a history of either drug or combined drug and alcohol problems. Furthermore, a majority of those patients with drug problems

(58%) were illicitly using drugs in the hospital. Compared to nonusers, drug users tended to be younger, more likely Black, and with the same incidence of schizophrenia (83%). Half of the drug users were taking drugs 3 or more times a week, with marijuana used by almost all (96%), and alcohol by half (48%) the users. As with the alcohol users, negative attitudes toward treatment were commonly found among these drug abusers, along with cliquishness, secretiveness, and the need for greater supervision.

These considerable rates of alcohol and drug use in the VA hospital bode poorly for patients if substance abuse problems go untreated while they are in the hospital. Their attitudes are poor and the likelihood for abuse upon discharge is considerable. As with patients in acute general hospitals, the need for proper attention to alcohol and drug problems among general psychiatric patients is underlined in these studies.

Public Psychiatric Hospitals

Public psychiatric hospitals generally admit patients whose mental illnesses are acutely disruptive, severely debilitating, or life-threatening. Because of this, their populations are revealing with regard to the relationship between substance abuse and severe mental illness. One early study drew on statistical reports on internees in facilities operated by the Department of Mental Hygiene of New York State [16]. Admissions between 1951 and 1960 in 18 hospitals revealed a notable finding in relation to patients who had psychoses due to alcohol. Whereas the number of admissions overall had declined over the course of this period, the number of patients admitted for psychosis due to alcohol had increased (from 6.8 to 8.1 per 100,000). An examination of this population of alcoholic psychotics revealed that the large majority (82.5%) were from metropolitan areas and that the incidence of alcoholic psychosis among Blacks was almost 4 times that among Whites. Significantly, however, these were not the only patients whose admission may have been precipitated by alcohol use, as it was found that approximately 17% of all admissions overall were known to be "intemperate users of alcohol."

These findings are augmented by McCourt *et al.* [17] who studied patients at Boston State Hospital. Only 30% of this sample ($N = 115$) were given a diagnosis of alcoholism, but more than half (57%) had at least one trouble area due to drinking, and a quarter (24%) of the patients themselves reported that they were alcoholics. The authors conclude that although state mental hospitals have many diagnosed alcoholics, they may indeed have many more admitted under other diagnoses.

Similar results were found in a study conducted on patients admitted to psychiatric facilities in North Carolina [8]. Two samples were evaluated, one in a state hospital ($N = 100$) and the other in a veterans hospital ($N = 320$), and in both the incidence of alcoholism was found to be 24%. The breakdown among alcoholics by primary diagnosis was manic depressive (33%), schizophrenic (22%), psychoneurotic (25%), and depressive (20%). The authors comment with some pessimism on the plight of the treating physician, pointing out that he often responds "with disgust" to individuals who use alcoholic excessively. On the other hand, if he were to respond with compassion, recognizing alcoholism as an illness, he may, according to the authors, experience undue optimism, referring the patient to Alcoholics Anonymous in hope of a positive outcome, and then finding that the patient responds poorly.

Admissions precipitated by drugs of abuse were also studied in a population of diagnosed drug abusers ($N = 112$) who were admitted to Bellevue Psychiatric Hospital, a large acute public psychiatric facility in New York City. In this study Hekiman and Gershon [19] grouped patients by their primary drug of abuse. All were admitted in either a psychotic, toxic, or withdrawal state, and represented overall approximately 5% of admissions to the hospital. Those whose admissions were precipitated by heroin (20%) were most often diagnosed as sociopathic, and their admissions were generally related to toxic or withdrawal states. On the other hand, admissions precipitated by marijuana (7%), amphetamines (20%), or psychedelics (42%) were generally diagnosed as schizophrenic; these latter patients typically had a preexisting history of psychotic symptoms which were exacerbated by the drug of abuse, reflecting the considerable vulnerability of more seriously disturbed patients exposed to substances of abuse with psychotomimetic potential. Additional patients (12%) were admitted for use of barbiturates, cocaine, glutethimide, and other drugs.

The difference in severity of pathology among groups using different drugs was also evident in that only a small number (19%) of heroin addicts required further hospitalization after their Bellevue admission, whereas marijuana abusers required it in half the cases. The authors underline the importance that over half the patients in the marijuana, amphetamine, and psychedelic groups were considered schizophrenic or were treated for this condition before they resorted to their drug use. This underlines the puzzling but compelling interrelationship between drug abuse and psychopathology in certain schizophrenic patients, and the need to clarify what impact the combination has on the course of these patients' illness.

Private Psychiatric Hospitals

Drug use and attendant psychopathology are clearly affected by culture and subculture. This is seen in the case of private psychiatric hospitals, which typically cater to a more affluent and better educated population than public facilities. It is particularly evident in the patterns of drug use that emerged in the counterculture era, which peaked in the early 1970s. For example, one evaluation carried out on patients 25 or younger at the Institute of Living in Hartford, Connecticut, revealed a population (N = 167) that was almost exclusively White, from middle- and upper middle-class socioeconomic backgrounds [20]. Most of these patients (73%) had used marijuana, and fully half (52%) had used LSD or other hallucinogens. An appreciable number had also used amphetamines (62%), barbiturates (44%), and narcotics (34%). Altogether, 74% of the patients studied had used one of these drugs. Significantly, among those who did use drugs, the frequency of use was quite high; about half of those who had used a given drug, had used it at least 30 times (45–68% for the various drugs, respectively). The use of any drug before the age of 15 was likely a predictor of more serious subsequent involvement, in particular, of the eventual use of barbiturates and narcotics. The authors observed that for these adolescents, drug use was in part a way of coping with life difficulties and intrapsychic stress, but one which in actuality only created further conflict.

These authors did not examine the relationship between drug use and the circumstances precipitating admission. It is clear, however, that during the counterculture era, considerable psychopathology was precipitated by psychotomimetics *per se*. A considerable decline in use of this category of drugs has, however, taken place since then. For example, federal surveys on high school drug use [21] show that the incidence of hallucinogen use among students within the last 12 months had declined by almost half (from 11.2% in 1975 to 6.5% in 1984). Reports are available, however, on the incidence of psychopathology precipitated by hallucinogens during the period when they were more popular [22–24].

The use of drugs among patients admitted to private facilities during the counterculture era is further evident in a study of patients (N = 224) admitted to Hillside Hospital, a private psychiatric institution in New York City.

Ghen and Klein [25] reported a sixfold increase in the incidence of illicit drug use between 1960 and 1967 (from 5 to 31%). They were able to study a sample of 70 abusers from 1967 patients, and divided them into 39 "extreme" drug users, characterized by almost habitual use of 2 or more drugs, and 31 mild to moderate abusers. Drug abusers on the whole tended to have a higher IQ than other patients at the hospital (X = 113 vs 103), reflecting the culture of the time. Marijuana, amphetamine, and LSD were the most commonly abused drugs. Notably, the large majority (85%) of the extreme drug users were diagnosed as having character disorders, with only a small number (5%) of schizophrenics among them. Corresponding figures for the mild to moderate drug users showed a considerable shift toward schizophrenia (58 and 26%, respectively), and those for the patients who were not drug users showed an even greater shift (46 and 40%). Again, these findings reflect the incidence of character disorder among patients admitted with histories of drug use. Based on these findings, the authors suggest that for these young middle-class psychiatric patients, involvement in illicit drugs was part of a subculture which encouraged drug use and promiscuous sexual activity, too.

Patients at the same hospital, age 15 to 25, were subsequently studied to ascertain their use of illicit drugs *during* the hospital stay [26]. Whereas the previous study was done retrospectively by chart review, this one drew on weekly urinalyses carried out over the course of an average of 27 weeks, beginning with the time of admission. Analyses were done only for barbiturates, amphetamines, and narcotics, though, due to limitations in the technology available at the time. At the time of admission, 52% of patients had urines positive for one of these drugs, and over their course in the hospital, 60% were positive for barbiturates (53%), amphetamines (24%), or narcotics (13%) at one time or another. Since no patient was found to use narcotics more than 5 times or amphetamines more than 7, the authors speculate that the more heavily addicted patients may well have left the hospital early in their stay. They further pointed out that in order to ascertain the episodic use of drugs in the hospital, it is necessary to do multiple testing on at least 10 occasions. Because of possible interactions between psychotropic medication and drugs of abuse, they suggest that urine testing should be considered as a general policy among hospitalized patients.

Some Observations

Given the apparent magnitude of the dual diagnosis problem, it is notable that there are so few recent studies on the epidemiology of this syndrome.

There are no published data on prevalence of dually diagnosed patients in the general population, and only a few of the studies on patients in the general psychiatric population cited here have been published since 1980. Nonetheless, there is considerable need for further empirical observations. In the first place, we know little about the relationship between the nature of dual diagnosis in the general population relative to how it presents at treatment facilities. Furthermore, more sophisticated diagnostic instruments which have been developed in recent years, such as the Diagnostic Interview Survey, have yet to be applied to dually diagnosed populations for more accurate psychiatric assessment. Because of this, little is known about the relative utilization of mental health services for this syndrome or the need for services.

Because of changes in the kinds of drugs abused by the general public, it is important that the epidemiology of specific drugs abused be examined. Such trends in drug use are illustrated by the considerable decline in psychotomimetic use in recent years, and the increase in cocaine use—particularly in the "crack" form. This latter agent, because it allows for rapid onset of action at high doses of free-base cocaine, generates a major onslaught on the mental health of persons who are already psychiatrically disabled.

Dually diagnosed patients are generally found to have a lower incidence of schizophrenia and major depressive disorder than other general psychiatric patients. Conversely, dually diagnosed patients have a higher incidence of character disorder. Why is this? It may be that the more severely disabled patients lack social skills which are necessary to sustain a drug-abuse habit. Alternatively, patients with less debilitating diagnoses may be vulnerable to drug-induced crises of adaptation which precipitate the need for psychiatric treatment. Furthermore, it may be that drug-seeking is one manifestation of character disorder and the complex adaptive problems which it precipitates.

Studies on chronic-stay facilities such as private psychiatric hospitals and Veterans Hospitals illustrate that psychiatric patients are prone to using drugs during their hospitalization so long as the opportunity presents. It is likely that such patients use drugs to an appreciable extent when engaged in ambulatory care, too. Little attention has been paid to this problem in order to assess its psychiatric sequelae and impact on rehabilitation, and almost none has been paid to the specialized treatment necessary to address such patterns of abuse. Given the findings reported here, however, it is reasonable to assume that an appreciable portion of morbidity and treatment failure among chronic psychiatric patients is due to their ongoing patterns of drug and alcohol abuse.

DIAGNOSIS

We will now review those studies that address the specific diagnostic problems resulting from the combination of each psychiatric disorder and substance abuse.

Affective Illness

The combined clinical picture of depression and substance abuse appears to be fairly common. While secondary depression ranges from 28 to 70% among alcoholics [27, 28] and from 32 to 46% among opiate addicts [27], addiction also frequently complicates primary depression. In an inpatient study [29] of male psychiatric patients ($N = 279$), for example, McLellan *et al.* found that 38 (44%) of 87 depressives reported serious abuse of alcohol or other substances. Fifteen patients were alcohol dependent, 12 were addicted to barbiturates, 8 were heroin addicts, 2 patients abused amphetamines, and only 1 reported abusing hallucinogens. Depression, on the other hand, has been observed frequently among alcoholics. Schuckit [30], in a retrospective study ($N = 577$) that included face-to-face interviews with male alcoholics and two relatives for each patient, found that 30% of these primary alcoholics had suffered from at least one secondary affective episode during their years of heavy drinking.

Not surprisingly, the overlap of symptoms of affective illness and substance abuse frequently lead to diagnostic confusion. Descriptive dilemmas include problems in differentiating alcoholism from drinking on one hand, and feelings of sadness from major affective illness on the other. Weissman *et al.* [27] and Schuckit [31] have argued that the symptom patterns of depressed alcoholics are similar to those of nonalcoholic depressives. Keeler *et al.* [32], for example, administered several diagnostic tests to a group of recently detoxified alcoholics ($N = 35$). Sixty-six percent of the MMPIs and 43% of all Zung depression scales obtained were compatible with a diagnosis of depression. Keeler *et al.* [32] and Liskow *et al.* [33] found that most depressions identified during alcohol detoxification subside following a period of 2 to 4 weeks of abstinence. Similarly, Pettinati *et al.* [34] in a 4-year follow-up study ($N = 133$) failed to observe evidence of significant depression in the MMPIs of a group of abstinent alcoholics.

The above described studies suggest that temporary depressive symptoms can be expected during the course of alcohol abuse. There appears to be general agreement that in 90% of heavy drinkers of either sex who display symptoms of both alcoholism and depression, the diagnosis is alcoholism and not primary affective illness [30, 35].

Disorders of affect also confound the differential diagnosis during withdrawal states from other drugs, such as amphetamines and cocaine [36], opiates [37], and barbiturates [38], and during the recovery phase of phencyclidine (PCP) intoxication [39].

Regarding bipolar illness and alcohol abuse, it seems that while the prevalence of alcoholism among bipolar patients is not higher than that of the general population [5], problem drinking complicates the clinical picture of at least 20% of acutely manic patients [40, 41]. Bipolar patients are also reported to frequently abuse other substances such as cocaine and amphetamines [42]. In an uncontrolled inpatient study (N = 36), for example, Estroff *et al.* [42] found evidence of at least one drug of abuse in 41% of bipolar manics, in 30% of bipolar depressed, and in 43% of bipolar mixed patients. The generalizability of these findings, however, is limited since the sample of patients studied included subjects who had been initially admitted for problems related to primary drug addiction.

Schizophrenia

The prevalence of substance abuse among schizophrenic patients is unclear. Ambulatory schizophrenics have not been found to abuse alcohol more often than the general population. Rimmer *et al.* [43] in a controlled adoption study (N = 33) identified alcoholism in only 3% of a sample of Danish schizophrenic adoptees. This small prevalence of alcoholism was not different from that found in the control group of nonschizophrenic adoptees. Studies on inpatient schizophrenics, however, have yielded much higher rates of alcoholism, ranging from 14% [29] and 22% [18] to 63% [44]. McLellan *et al.* [29] studied a group of hospitalized schizophrenics (N = 141) and found that 44 (31%) had histories of alcoholism. According to this study, about half of all inpatient schizophrenic males can be expected to suffer from secondary addiction, particularly amphetamines, alcohol, and hallucinogens.

In the clinical context, two factors account for the diagnostic dilemmas arising between substance abuse and schizophrenia. Secondary alcoholism or other substance abuse can mask an underlying schizophrenic disorder [18]. For example, it has been proposed that alcohol can serve as a stabilizing function (especially of anxiety) in schizophrenics, thereby obscuring the expression of diagnostic symptoms [45]. Alternately, although the overall prognosis is that of schizophrenia and not of alcoholism [46], the clinical picture of the severely alcoholic schizophrenic patient is likely to be dominated by frequent intoxications and overall alcoholic behavior [45]. A second source of diagnostic confusion is the group of psychotic syndromes (characterized by hallucinations, delusions, and other disorders of thought, affect, and behavior) that frequently affect substance abusers, not only during withdrawal states from alcohol, barbiturates, and other central nervous system depressives, but also during acute intoxications with hallucinogens, cocaine, amphetamines, marijuana, lysergic acid, phencyclidine, and inhalated substances.

Antisocial Personality Disorder

Although both alcoholism and antisocial personality disorder (ASPD) often share a variety of clinical characteristics such as problem drinking, positive family history of alcoholism, and the commission of asocial acts, current data from family and clinical studies strongly suggest that sociopathy and alcoholism constitute, in fact, two different clinical entities [46, 47].

ASPD is frequently complicated by secondary alcoholism [47] and other drug abuse [8, 48]. Lewis *et al.* [47] studied the prevalence of addiction disorders in a group of medically hospitalized patients of both sexes (N = 412). Twenty-five percent of all males diagnosed as ASPD, and 6% of their female counterparts, were found to suffer from both alcoholism and other drug dependence.

In a 1-year follow-up outpatient study [46] of men admitted to a Veteran's Hospital because of alcohol problems (N = 577), Schuckit found that while the differentiation between sociopaths and primary drug abusers were made difficult because of the similarity in substance abuse patterns in both disorders, sociopaths could generally be distinguished from primary alcoholics. Patients diagnosed as ASPD were found to develop problem drinking at an earlier age, suffered from more severe alcohol-related life problems, and also abused other drugs more often than primary alcoholics. Both primary drug abusers and ASPDs had a greater likelihood of drug abuse, more police and social problems, and demonstrated more adverse clinical outcomes than the group of primary alcoholics studied. The more severe patterns of alcoholism among ASPD than among primary alcoholics reported in this and other studies [48-50] have been explained by Lewis *et al.*, who postulated that ASPD increases both the early exposure to problem drinking and the risk of alcoholism once the vulnerable individual is exposed [47].

Anxiety Disorders

In light of multiple reports available, secondary addiction in patients with severe anxiety disorders is not uncommon. The prevalence of alcoholism in patients suffering from panic attacks has been consistently reported to range from 10% [51, 52] to 15% [53]. Conversely, in primary alcoholics, agoraphobia has been found in 14% [54] to 16% [55]. Generally, significant symptoms of anxiety can be expected in at least 44% [56] of alcoholic patients.

Because of the frequent occurrence of anxious feelings during drug and alcohol withdrawal [51], an adequate history confirming the existence of anxiety disorder and a period of observation of at least 2 weeks [46] of abstinence are necessary in order to diagnose a primary anxiety disorder.

Quitkin *et al.* [55] reported that a large number of patients who suffer from panic attacks and/or a phobia (generally agoraphobia) attempt to mitigate their symptoms, including the anticipatory anxiety, by self-administration of alcohol and other depressant drugs such as barbiturates [51]. Additionally, alcohol abuse has been observed in individuals suffering from posttraumatic stress disorder whose frequent nightmares are apparently relieved by this drug's ability to suppress REM sleep [55]. Quitkin *et al.* suggest that the clinical presentation of this dual disorder is frequently dominated by the secondary addiction [55], and that the successful diagnosis of a primary anxiety disorder requires an active search for a history of anxiety attacks or evidence of phobias in the past [51].

TREATMENT CONSIDERATIONS

One single research work attempts to remedy the prevailing lack of data on the concurrent treatment of psychiatric disorders and addiction. Kofoed *et al.* [58] conducted a pilot, outpatient study ($N = 32$) on a dually diagnosed population treated in an ambulatory program that incorporated techniques from both psychiatric and substance abuse treatment. For example, although it emphasized symptom control and compliance with prescribed medication, abstinence from drug and alcohol represented its main focus of treatment. The program is described by the authors as specifically designed for those patients seriously impaired by both their primary psychiatric illness and their secondary addiction, who had derived little or no benefit from previous treatment experiences. Following an initial stabilization that included brief hospitalization in some cases, patients attended weekly groups, were routinely prescribed disulfiram, and were encouraged to attend Alcoholics Anonymous and Narcotics Anonymous. Abstinence was monitored by surprise urine screenings and breathalizer assessments. Patients were also expected to develop ancillary support abstinent groups, usually Alcoholics Anonymous, and had a variety of adjunct treatments made available to them, such as individual and family counseling, skill training, and day treatment. DSM-III diagnoses were made and retrospective symptom scores were obtained from subscales of the Addiction Severity Index. Since strict criteria for retention in treatment were applied, the authors equated retention with treatment success.

The results of the study include a very high dropout rate of 60% within 2 months. A second group of only 11 patients (34%) remained in treatment for 3 or more months. While these two groups were demographically similar, the distribution of psychiatric diagnoses between the two groups differed, mainly due to the overrepresentation of personality disorders in the early dropout group. Finally, contrary to other reports [59, 60], symptom severity and history of previous hospitalizations did not seem to influence treatment retention. Retention, however, was enhanced in the presence of a previous experience in outpatient treatment.

With the exception of addicts with personality disorder for whom no specific treatment was conceptualized, the authors suggested that dually afflicted patients warrant treatment along the following guidelines: (1) Initial hospitalizations for detoxification (which would also facilitate both the evaluation and management of suicidal depressive and manic states) followed by open-ended outpatient treatment of both disorders by a multidisciplinary staff; (2) treatment specifically aimed at symptom relief; (3) discriminant use of legal coercion; and (4) use of disulfiram as a treatment adjunct for those stable patients involved in ongoing treatment.

The validity of these treatment recommendations is limited, however, due to the very short duration of the study, the lack of treatment technique controls, and the small patient sample. These shortcomings prevent both comparative determinations of long-term outcome according to psychiatric diagnoses and reliable assessments of the clinical effectiveness of different treatment modalities.

We will now review the specific treatment studies regarding each of the psychiatric diagnoses complicated by substance abuse considered in the previous section.

Affective Illness

Since very high suicide rates have been reported among addicted depressives [61], most authors recommend a period of hospitalization during the initial phase of treatment for these patients [42, 46]. Nonetheless, the vast majority of serious depressions observed during detoxification of alcohol and other drugs can be expected to remit following a few weeks of abstinence [32, 57]. Rounsaville *et al.* [62], for example, studied depressed opiate addicts ($N = 157$), following them over a 6-month period to ascertain the course of their depression. He found that improvement of depressive symptoms was related to retention in treatment but was not the result of specific antidepressant pharmacotherapy and did not differ across treatment modalities.

The outcome of primary depressives with associated addiction problems may prove to be different from that of primary addicts. It has been suggested, for example, that depressives with alcoholic problems may have a better outcome and stand a better chance of attaining long-term abstinence than primary alcoholics [46]. Appropriate comparative outcome studies, however, are necessary to clarify this important question.

Another important issue in the treatment of affective patients with secondary addictions is the use of antidepressant and antimanic medication. The effectiveness of antidepressants and lithium carbonate in treating the primary affective disorder and their contribution to drug relapse prevention, however, have not been determined. Neither has the comparative value of different treatment modalities been established for this population. The single outpatient study available [58] on dually diagnosed patients previously reviewed included only 4 patients with affective disorders (bipolar disorders). Since neither their demographic and clinical characteristics nor their comparative rates of retention in treatment are described in the study, no diagnostic-specific recommendations can be drawn regarding their treatment.

Schizophrenia

The early identification of schizophrenic addicts in the treatment context have been strongly recommended, mainly because of the need to respond promptly to the particularly difficult management problems that these patients represent [42, 46, 63]. The addicted paranoid schizophrenic, for example, has been described as among the most difficult to treat [64]. Illustrating the difficulties in treating these patients, as already mentioned, is the finding by Alterman *et al.* [13] that more than half of the inpatient schizophrenic alcoholics included in their study were reported to drink while still in the hospital.

The diagnostic picture of addicted schizophrenics, particularly at the beginning of treatment, is frequently confusing and is often the cause of delay of appropriate treatment planning [46, 63, 65]. Additionally, the exacerbation of schizophrenic symptoms by drug abuse, the extremely high suicide potential in this population [46, 66], and the frequent difficulties in engaging schizophrenic addicts in treatment [58, 67] are all factors that seriously compound the management of these patients. Complicating matters, the staff generally lacks appropriate training in the simultaneous treatment of both psychosis and addiction [58, 63]. Ottenberg [68] reported on the ability of the psychotic addict to disrupt the entire program of a psychiatric unit. Alterman *et al.* [13, 14, 70], for example, in a study of inpatient addict schizophrenics ($N = 101$), observed that at least 30% of these patients represented severe management and treatment problems for the staff. Not surprisingly, schizophrenic addicts frequently are either altogether refused admission or prematurely discharged from both psychiatric and detoxification wards [69, 70].

There is very little data on the concurrent ambulatory treatment of schizophrenic addicts and their outcome. In the outpatient pilot treatment study [58] previously described on 32 dually diagnosed individuals, only 6 out of 16 alcoholic schizophrenic patients remained in treatment for at least 3 months. Those patients in the study who remained this long in treatment were the ones most likely to have had previous mental health treatment, suggesting that even one psychotherapy experience may eventually contribute to the patient's ability to comply with treatment even in the absence of abstinence. Although the sample size in this study precludes reliable comparisons of retention rates among different psychiatric disorders, schizophrenics did not seem to drop out of treatment earlier or more often than other patients, as would be expected in view of the reported difficulties erienced by schizophrenic addicts in establishing relationships with chologically oriented treatment facilities [64]. Panepinto *et al.* [71] orted that schizophrenics, unlike patients suffering from personality rders, consistently attended brief, symptom-oriented visits to the inter- in a treatment program, but simultaneously failed to become involved h other staff members. As pointed out by Gottheil [63], this behavioral tern suggests that schizophrenic alcoholics may be more compliant with pharmacologically oriented treatment program which encourages only nimal exploration of thoughts and feelings. While neuroleptics are in- cated in the treatment of the primary schizophrenic process, there are no nical studies available to help clarify the indications and overall contribu- n of neuroleptics in the treatment of secondary addiction.

An important issue in reference to pharmacotherapy in this population is use of disulfiram. A controversy about disulfiram administration in izophrenics exists that revolves mainly around the reported psychotic actions it occasionally induces with consequent risk of schizophrenic lapses [72]. Kofoed *et al.* [58], however, report no complications in outine disulfiram administration to the dually diagnosed population eviously described. In fact, their overall disulfiram compliance rates and dividual patterns of compliance were reported to be almost identical to hose reported in alcoholics without other psychiatric illness [73].

An important consideration for the ambulatory treatment of addicted chizophrenics concerns their reported failure to integrate with large roups. Because of their difficulties in tolerating and participating in highly ohesive groups without becoming passive or paranoid [64], referral of hese patients to groups such as Alcoholics Anonymous and Narcotics nonymous has not been recommended.

ntisocial Personality Disorder (ASPD)

Not much has been reported on the concurrent treatment of sociopathy and addiction. The few reports on addicted ASPDs response to ambulatory treatment uniformly describe these patients as having the worst short- and long-term prognoses of all dually diagnosed patients [46, 55, 58]. Schuckit [46], in a 1-year follow-up study of male alcoholics ($N = 577$), for example, reports that patients with antisocial personality disorder demonstrated more adverse outcomes than other groups of primary alcoholics, substance abusers, and affectively ill patients. In agreement with other reports [74], sociopaths in this study showed a higher prevalence of police problems, using weapons while drunk, taking other drugs, and lack of stable residence than other psychiatric patients. They also dropped out of treatment earlier and had less abstinent days than primary addicts and alcoholics.

In another study ($N = 110$), Woody *et al.* [75] observed that psychotherapy outcome of addicted sociopaths, although generally poor, was enhanced in the presence of associated depression. These authors speculate that depression appears to be a condition that allows the sociopathic patient to be amenable to psychotherapy.

The only information available on substance abuse by other personality disorders derives from Kofoed's outpatient pilot study [58]. Unlike all other patients suffering from a different psychiatric disorder, most patients in this study diagnosed as having borderline personality disorder (7 patients, 22% of the sample) dropped out of treatment by 4 months, earlier than all other psychiatric patients. Upon analysis of their findings, the authors declare themselves uncertain of the correct treatment approach for addicts with personality disorders.

Anxiety Disorders

Quitkin *et al.* [51, 55] described a treatable syndrome in which the recurrence of both a panic disorder and an associated secondary addiction can be successfully prevented by proper pharmacological treatment of the primary anxiety disorder with tricyclic antidepressants. In an outpatient study [51], the clinical courses of two small groups ($N = 10$) of addicted anxious patients suffering from panic attacks, phobias, and anticipatory anxiety were compared during a period of 6 months to 3 years. Only the group treated with imipramine did well and did not return to alcohol or drug abuse.

More studies are necessary to corroborate these findings. The proper treatment for other anxiety disorders complicated by addictions has not been determined.

OBSERVATIONS

This review was undertaken because of the serious clinical problems, largely unattended, which have been posed by dually diagnosed patients. We have summarized the current literature on the place of presentation, diagnosis, and treatment of persons presenting for general mental illness who have concomitant alcohol and drug abuse problems. What emerged was a problem of considerable dimension, one seriously compromising the operation of the mental health system, and one on which relatively few specialized studies have been carried out. A number of factors contribute to this unfortunate situation.

In the first place, teasing apart the symptoms of combined addictive and general psychiatric illness in combination is quite difficult, even though this problem is very common. Our diagnostic nomenclature has been developed for discrete, single illnesses, but the entirety of addictive and general psychiatric problems is a good deal more complex than the sum of its parts. It may be necessary to develop a nomenclature for certain concomitant illnesses; for example, a characteristic pattern of depressant abuse (such as alcohol), different from the one generally described, emerges from the dysphoria accompaning chronic mental illnesses. This pattern often remits with the treatment of the primary illnesses.

Second, patterns of drug use have changed considerably with the passage of several years. Pure opiate use has been replaced by methadone maintenance combined with polydrug abuse; phencyclidene has been replaced in many emergency rooms by freebase cocaine ("crack") as a primary precipitant of drug-induced psychosis. While the federal emergency room reporting network has been useful in tracking changes in drug abuse patterns, little has been done to examine changes systematically in pathophysiology of the dual diagnoses presenting with these drug-abuse patterns. Much more intensive studies on both symptom presentations and the effects of drugs on psychopathology are needed.

Finally, new modalities are needed in the area of treatment. We have only begun to use modalities for treating drug abuse when it occurs independent of other psychiatric illness. Not surprisingly, the few studies noted here that do address combined problems utilized established techniques. Much more remains to be done about the innovative application of psychotropic agents to subgroups of dually diagnosed patients and of newly developed psychosocial modalities which address combined cognitive, affective, and addictive symptoms in an integrated manner.

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CULTURAL DIVERSITY AND PSYCHIATRIC REHABILITATION

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— CHAPTER THIRTEEN

Cross-Cultural Mental Health Treatment

LILLIAN COMAS-DÍAZ

INTRODUCTION

This last chapter touches on some aspects of the clinical practice of cross-cultural mental health not addressed in previous chapters. Cross-cultural mental health is an emerging and growing field in the United States. Historically, this treatment approach has evolved through the influence of (1) indigenous, folk-healing practices, (2) psychoanalytic anthropology, and (3) the delivery of mental health services to ethnic minorities.

The first documented anthropological accounts of indigenous or folk healing date to the nineteenth century. These accounts mention practices such as psychic healing, but present them as ethnographical curiosities and are silent as to any behavioral change process attendant to treatment, according to Draguns (1981). However, as ethno- and transcultural psychiatry developed, adherents proclaimed the importance of the psychiatric qualities of shamans, *curanderos*, witch doctors, Yoruba priests, spiritualists, Navaho

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healers, and so on (Kiev, 1972; Moffatt, 1974; Torrey, 1972). (In this volume, Ezra E.H. Griffith and John L. Young present the psychological merit of some of these practices.)

The second major influence in the development of cross-cultural mental health treatment was the advent of psychoanalytic anthropology. As its major exponent, George Devereux laid the foundation by studying cultural factors in psychoanalytic therapy and using his psychoanalysis of Plains Indians and culturally marginal White patients as the basis of his findings (Devereux, 1953). Several other therapists began to disseminate their findings using psychoanalytically oriented therapy in a cross-cultural context. For instance, Sommers (1964) studied identity disorders in patients with dual cultural memberships. More recently, Gehrie (1979), using a psychoanalytically informed, anthropological research model, has asserted that culture is an internal representation and that, as such, it ought to be an integral aspect of psychoanalytic treatment.

A third influence on the development of cross-cultural treatment has been the challenge to the mental health profession to deliver effective services to ethnic minorities, for example, Blacks, Hispanics and Latinos, Asian Americans and Pacific Islanders, and American Indians and Alaska natives. The civil rights movement and passage of the Community Mental Health Act have added impetus to this challenge. Issues such as ethnicity and social class, minority group membership, dysfunctional versus adaptive behaviors, therapist–patient match, and culturally relevant treatment are still debated.

Meanwhile, cultural pluralism is emerging as a distinct feature of American society. The United States is becoming a "nation of newcomers" (Piers & Piers, 1982); the massive influx of immigrants is currently "changing the face of America" (Immigrants, 1985). The melting pot theory is proving to be obsolete as our society is being transformed into a nation of ethnocultural diasporas. Given this context, the availability of effective cross-cultural mental health services is imperative.

THERAPIST–CLIENT DYAD

Individuals in an alien cultural environment undergo a process of adjustment to their new settings that involves struggling with their ethnocultural identities. Erikson (1959) has theorized that individuals in crisis situations, such as cultural transition, experience a heightened awareness of their identities, undergoing what he calls a transitory, excessive identity consciousness. Cultural transition tends to move individuals along the developmental pathway at a faster rate than other external factors. Thus during acculturation or a period of sociocultural transition, their self-images may undergo dramatic changes and lead to subsequent identity crises. According to Sluzki (1979) the effects of cultural transition are still manifest in families generations after a migration has occurred. (See Behnaz Jalali's in-depth discussion of this issue in the first chapter of this volume.)

The role of therapists in helping patients who have made cultural transitions is a complex one. Such patients are likely to have worldviews that differ from their therapists' and, at times, views that conflict with the western notion of mental health. Patients entering therapy also may experience considerable anxiety about the ethnocultural differences between themselves and their therapists (Sue, 1981). Suspicion, apprehension, anger, and preoccupation with self-image and identity are likely to surface, putting the therapist's trustworthiness and credibility to a severe test.

Research demonstrating the therapeutic benefits of therapist–patient ethnocultural similarity is inconclusive (Cortese, 1979; Jones, 1978). Nevertheless, research does show that a therapist's effectiveness tends to depend on his or her perceived credibility (Sue, 1981). Regardless of the therapeutic orientation, one of the crucial factors in successful therapy seems to be the therapist's understanding and sensitivity to the patient's ethnocultural background (Griffith, 1977). In determining what characteristics make for a therapist's successful "minority style," Smith and his colleagues (1978) say it is an understanding of the biculturalism of patients in a cross-cultural setting that is essential.

In defining pluralist psychotherapy, Padilla (1981) asserts that its goal is to help patients clarify their personal and cultural standards. In order to accomplish this, the pluralistic therapist needs to understand both the patient's ethnic group and the dominant group culture and know the points of contact between the two cultures and the process by which the cultural standards of each influence the patient. Padilla adds that pluralistic therapy is a complex task when the patient is culturally marginal, (i.e., has a bicultural background without a dual ethnocultural identification). In this case, the therapist must integrate the dual ethnocultural experience into the therapeutic process. Thus the therapist, with the patient's help, must decide how much separation from and/or how much acculturation to the dominant culture is necessary to effect a successful therapy.

Padilla's assertions acquire added relevance when patients use the therapeutic session as a forum for the expression of conflicting ethnocultural identities. For example, Gómez and his associates (1982) state that the majority of patients they studied manifested identity conflicts through an expressed preference for their original culture over the host culture. They found that patients complained when their therapist had a different ethnocultural background. Based on these findings, it can be speculated that the effective therapist may be perceived as a guide, fostering ethnocultural identifications in the process of identity formation. Similarly, Varghese (1983) states that the fundamental task in psychotherapy is to be aware of the patient's feelings toward the therapist, sometimes by monitoring one's own feelings, reflecting back to the patient, and thus gaining an empathic understanding of the patient.

Elsewhere, we (Comas-Diaz & Jacobsen, 1987) introduce a model of the impact of cultural dislocation on the therapeutic process. We note that culturally translocated individuals often attribute ethnocultural qualities to their therapists. For example, a dark-skinned Brazilian male suffering from depression says to his Afro-American male psychiatrist: "You can understand my predicament because we Black people always have had bad luck." After a year of treatment, a first-generation Portuguese female says to her female Puerto Rican therapist: "We can conduct the treatment in Spanish. I know the language because I was once engaged to a Cuban man." A Black female says to her Asian-American male therapist: "Although I grew up as a Baptist, I am now involved in Eastern philosophies and perhaps you can help me heal my soul." Although these quotes can be interpreted in the context of diverse theoretical orientations, we believe that they do demonstrate that patients who have experienced cultural dislocation may presume and then attribute to their therapists certain ethnocultural characteristics that may or may not be accurate.

As an auxiliary therapeutic tool, ethnocultural identification can help the patient manage cultural values, negotiate transitional experiences, and cope with the identity readjustment in an alien cultural environment. Within this framework the initial task of the therapist is to perform an ethnocultural assessment. This assessment involves the exploration of several stages in the formation of the patient's cultural and ethnic makeup. (In Chapter 6, Frederick Jacobsen provides a detailed description of the use of ethnocultural assessment aided by clinical methodology. Here, I will concentrate on the use of ethnocultural identification in the psychotherapeutic process.)

Should the ethnocultural assessment confirm that the patient's self-identity is indeed fragmented, the therapist actively fosters patient identification with his or her ethnocultural origin. In order to accomplish this, the therapist engages in three major therapeutic functions (Comas-Diaz & Jacobsen, 1987).

1. Reflection, whereby the therapist "mirrors" the ethnocultural pieces of the patient's fragmented self
2. Education, whereby the therapist guides the patient through a reformation of ethnocultural identity
3. Mediation, whereby the therapist helps the patient integrate his or her ethnocultural self into a consolidated sense of self

Reflection acknowledges the pervasive influence that ethnicity and culture have on the patient's life. The therapist underscores those aspects of the patient's life that reveal his or her ethnocultural identity conflict: "It is difficult for you to see yourself as ——— [ethnicity]," or "You avoid people from your community because they remind you of being ——— [ethnicity]." These statements communicate to the patient an awareness of his or her fragmented ethnocultural self.

Reflecting pieces of the fragmented ethnocultural identity conveys to the patient that the therapist understands the circumstances of biculturalism–multiculturalism. This can allow the patient to perceive the therapist as empathizing with his or her complex identity and thus facilitate the development of trust.

In executing the second therapeutic function, the therapist acts as a guide in the reconstruction of the patient's ethnocultural identity. The therapist provides a "safe" environment where the patient can examine his or her conflicted identity. By using directive approaches, the therapist helps the patient examine inconsistencies between aspects of his or her own ethnic background, and between his or her ethnocultural values and those of the second culture.

The third therapeutic function is the mediation between the ethnocultural identity and the personal identity. Here the therapist helps the patient to connect different aspects of the self to achieve a more integrated identity. According to McGoldrick (1982), restoring a sense of identity may require resolving cultural conflicts within the family, between the family and the community, and/or between the individual and the wider context in which the patient and his or her family function. During this mediation, the therapist encourages the patient to verbalize existing identity conflicts. Enunciations such as "It is confusing to you because, at times, you feel like a ——— [ethnicity] and at others you feel like an American" help the patient to "name" the identity conflict and hence initiate the reintegration process.

Ethnocultural identification follows a developmental framework, similar to Adler's (1975) model of the individual's adjustment to cross-cultural transition. Adler posits that the specific psychological and ethnocultural dynamics appear during and after the cultural transition. His model delineates progression through five stages: (1) initial contact with a second culture, where the individual is insulated by his or her culture of origin; (2) disintegration, where awareness of being different results in depression and withdrawal; (3) reintegration, where the second culture is rejected through anger and rebellion; (4) autonomy, where the person is able to negotiate different situations culturally, thus surviving new experiences; and (5) independence, where ethnocultural, social, and psychological differences are accepted and enjoyed. In this last stage, the individual is able to exercise choice and responsibility and to discern the cultural aspects of everyday interactions and circumstances.

As a therapeutic tool, ethnocultural identification can assist patients in progressing through the five stages of Adler's model. By mirroring the fragmented self, the first, or reflective, stage heightens the patient's ethnocultural awareness so that he or she can move toward Adler's developmental stage of autonomy. Finally, the third, or mediative, stage aims to enable the patient to achieve the final developmental stage of independence.

The following is a case vignette illustrative of the use of ethnocultural identification in cross-cultural mental health treatment. (The patient's identifying data have been changed to ensure confidentiality.)

> Nancy, a 25-year-old recently migrated Jamaican woman, was hospitalized because of the breakup with her lover. After discharge, she was referred to outpatient treatment with a diagnosis of brief reactive psychosis.
>
> During the first outpatient session, Nancy asked her therapist (a female Puerto Rican) if she knew the differences between Afro-Americans and West Indians. Initially, she responded to Nancy's question at its content level, affirming the legitimacy of the patient's inquiry into her therapist's cultural understanding. Later, when Nancy continued to make comments such as "I like being American, but I am not Black," or "I am part British and do not understand the English spoken by Black Americans," the therapist decided to perform an ethnocultural assessment.
>
> Results from the first stage of the assessment revealed that all of Nancy's relatives were Jamaican. Like Nancy's paternal grandmother, her mother had left Jamaica for another Caribbean island when she was in her thirties. At this point Nancy asked her therapist if she was Puerto Rican. When she responded affirmatively, Nancy noted that "Puerto Rico is a Caribbean island," suggesting a link between the therapist and patient.
>
> The second and third stages of the assessment revealed that Nancy perceived her immigration as a female duty; that is, she was following the examples set by her mother and paternal grandmother. Several sessions were devoted to the completion of the ethnocultural assessment, including an exploration of religious beliefs during which Nancy stated that she was raised as a Catholic. In the last stage of an ethnocultural assessment the therapist's own ethnocultural background is examined for potential overlap with the patient's. In this case the overlapping areas identified were: Caribbean background, upbringing in the Catholic faith, and the experience of cross-cultural transition.
>
> The results of the assessment provided the groundwork for the ethnocultural identification. During the initial stages in therapy, Nancy began

to discuss her relationship with her ex-boyfriend. She blamed herself for the breakup, stating that she had changed in the United States; that is, she was "no longer pretty." Exploration of this issue revealed that, as a light-skinned woman, Nancy was considered very attractive in Jamaica. In the United States, however, she was viewed as an attractive Black woman.

According to Brice (1982), a light-skinned Black is accorded more status than a dark-skinned Black in the British West Indies. In the United States, Whites are observed not to make the distinction: A light-skinned West Indian is "another Black." Thus Nancy's belief that she was no longer pretty was a reaction to being considered "attractive Black" as opposed to "attractive woman." Her self-identification had changed and so, too, her self-image.

In therapy, however, Nancy began to draw parallels between herself and her clinician. Enunciations such as: "You don't look White, but you don't seem to mind" or "Your hair is just like mine" were elicited as the clinician reflected back to Nancy the latent content of her self-dissatisfaction. Nancy began to identify the characteristics she shared with the therapist and to discover that, though they were devalued by herself, they were accepted by her therapist. This process continued through several sessions to help Nancy reestablish her identity as an attractive woman.

During this stage in treatment, a crisis emerged, where Nancy confessed that she had been "hanging out with some Rastafarians, smoking ganja." Assessment revealed that her cannabis smoking was sporadic and that she did it in order to "belong to the Jamaican community." The therapist then took an active and directive stance in helping Nancy reformulate her ethnocultural identity. She was helped in dealing with culture shock and the subsequent feelings of loss that she was experiencing. Therapy was the arena for mourning meaningful cultural objects, and for guiding Nancy in redefining her identity as a Jamaican woman living in the United States. This was done by encouraging Nancy to discuss how she did or did not fit into the Jamaican community in the city that she was living in, and by examining the differences between Jamaican women in Jamaica and Jamaican women living in the United States. This exploration, together with a look at the behavioral alternatives available to her and their likely consequences, provided Nancy with more self-awareness and a sense of empowerment.

At this stage in therapy, Nancy mentioned that she had the power of healing by the laying on of hands. This revelation was carefully examined within her ethnocultural context and did not appear to be pathological. The healing symbolism of the laying on of hands was perceived as Nancy's identification with the healing functions of her therapist.

> Nancy began to feel more comfortable and accepting of herself as she achieved an integrated ethnocultural identity. She was capable of managing cultural inconsistencies, such as being labeled "Black" when she grew up considering herself "colored." Within this context, she used therapy to help her cope with a new cultural reality: American racism. Furthermore, she was able to maintain her job and to act on her plans to attend college.

Ethnocultural identification was used as an auxiliary to dynamic-oriented therapy to treat Nancy's DSM-III atypical personality disorder. This case vignette illustrates how the fragmented ethnocultural identity can be at the forefront of the patient's clinical presentation. The therapist's awareness and active use of the ethnocultural identification facilitated the therapeutic work with this patient.

GENDER ISSUES IN CROSS-CULTURAL PSYCHOTHERAPY

Early on, culture imposes upon the individual the pervasive task of becoming a psychological male or female. Similarly, the socialization process involves the development of behaviors and feelings, in addition to a sense of self, that are considered culturally appropriate for each gender. Thus the role of each gender may develop differently, depending on the cultural context.

Gender issues have received special attention in mental health treatment. The relevance of sex roles has been highlighted in terms of potential distortion due to gender differences in communication and interaction, particularly in the psychotherapeutic context (Johnson, 1981). Kaplan (1979) argues that both patients and therapists bring to therapy remnants of their upbringing within a culture that values different characteristics for males and females. According to her, this upbringing can influence both the position taken by each member of the therapeutic dyad and the ways in which each perceives and interprets the behavior of the other.

Gender issues obtain added significance in cross-cultural psychotherapy, as they are one more variable to complicate the therapeutic process. Ethnic differences intertwined with gender variables can stymie the process and outcome of psychotherapy. Wilkinson (1980) asserts that the risk for misconceptions and other obscurations is highest when the patient is a female of an ethnic minority and the therapist is an Anglo male. Thus the need to analyze the ethnocultural gender interaction in cross-cultural therapy is critical. Yet most research on ethnicity and mental health has not been gender specific, leading Wilkinson (1980) to call for systematic studies that do take into account the clinical significance of the ethnicity and/or race and the sex of both patients and those who formulate theory and engage in clinical practice.

Ethnicity, Cultural Transition, and Gender Roles

According to Landau (1982), an individual or nuclear unit tends to feel extremely threatened when moving from a traditional, extended family into a new culture where nuclear independence in expected. Landau further posits that the threat leads the culturally relocated individual to place an intense emphasis on the culture of origin. Other studies reveal that ethnic values and identification with the culture of origin are retained for many generations after immigration has occurred (Greeley, 1981) and so, too, the effects of cultural transition are manifest in clinical situations generations later (Sluzki, 1979). Thus ethnicity is a major determinant of identity, playing a significant role in family life and personal development throughout the life cycle. It fulfills the basic psychological need of belonging and having historical continuity (McGoldrick, 1982). Indeed, recent immigrants as well as second-, third-, and even fourth-generation Americans differ from the dominant culture in values, behaviors, and life-styles (McGoldrick, 1982).

Gender roles tend to be affected by cultural transitions and subsequent cultural adaptation. O'Reilly (1985) states that, for women, the cultural transition is a transforming process. She believes that most immigrant men desire to return to the old country and the old ways because they had status in their homelands merely because they were males. On the contrary, women prefer to stay in the United States, even though they have to struggle with the "double day," that is, both performing the household tasks and working outside the home to help meet their families' economic needs. They prefer to stay, albeit paying a high price, because they achieve more autonomy, something hard to obtain in their homelands. For example, Puerto Rican women who migrate to the mainland tend to be actively engaged in the transculturation process of their society, due to the availability of opportunities and the existence of more egalitarian sex roles. Puerto Rican men tend to feel more comfortable within their traditional sex roles and, therefore are less involved in the transculturation process (Comas-Díaz, in press).

Culture shock may include confronting different sex role expectations, thus causing gender role confusion. High-level ambiguity about sex roles, dating, and sexual expression has been found among adolescent Cuban refugees, for example (Scopetta, King, & Szapocznik, 1977). The following case vignette is another example.

> Antonio is a 21-year-old Salvadoran male who immigrated to the United States aided by an American Christian group. He immigrated to a northeastern state where his girlfriend, who had left El Salvador 6 months before he did, resided. Antonio had a college education and was politically active in an underground movement in his country. His girl-

friend, whom he met in college, had been supportive of his role, though not politically active herself.

Upon entering the United States, Antonio began to live with a minister and his family (wife and three small children). After a few weeks, the minister took him into a mental health clinic for Hispanics. Antonio was complaining of insomnia, anxiety, depression, and "nerves." He received chemotherapy for his depression and subsequent individual therapy to help him in his "adjustment to this country" (patient's own words). During evaluation, it was revealed that Antonio had contacted his girlfriend, but that the relationship had turned sour. He explained that she was not "the way she used to be; not listening to him and being too independent." He attributed her change to "[becoming] an American woman." Antonio was encouraged to bring his girlfriend to therapy, but he refused because "he was no longer in love with her."

Antonio continued in therapy with a Hispanic female, dealing with his feelings about "what happened and what he did in El Salvador," in addition to his adjustment difficulties. Six months into treatment, he requested to see the medical backup, a Hispanic male. Antonio confided to him that he was experiencing severe problems at home. He stated that the minister's wife was sexually available and that he wanted to have sex with her. However, Antonio was conflicted because he did not want to betray the minister's trust and face the risk of being asked to leave. Upon exploration into this conflict, Antonio revealed that as a *macho completo* (complete male) he had to respond sexually to any female who signaled her availability. He added that, although he had a good relationship with his female therapist, the medical backup could "better understand his problem."

Gender–Ethnicity Interaction: Effects of Psychotherapy

Gender roles vary according to ethnicity and need to be identified to ensure effective psychotherapy. The following examples illustrate gender issues among three ethnic groups: Blacks, with their long history of residence in the United States; immigrant Greek women; and Hispanics, with varying degrees of acculturation to the mainstream culture.

The Matriarchy Myth: Blacks. Black American children are more likely than Whites to reside in single-parent households headed by females (Harrison, 1977), and research suggests that Black girls tend to identify with the image of the "strong Black woman" (Ladner, 1971). Schaffer (1981) states that Blacks regard working outside the home as an appropriate female role and that Black girls are encouraged to rely on their achievements and not on men and marriage for future security. In contrast to what had been expected of Anglo girls, educational and occupational aspirations are accepted and encouraged for Black girls. In short, it appears that the Black female is socialized to be more independent, autonomous, and stronger than her Anglo counterpart. Given that Black women have had to work in order to survive economically, relationships between Black men and women generally tend to be more egalitarian than between Anglo men and women. Furthermore, research indicates that Black men and women have very similar expectations about gender roles in marriage and child rearing, and that both sexes prefer women to achieve a balance between self-actualization and family orientation (Schaffer, 1981).

That the Black female is socialized to be strong, independent, and a breadwinner may have led to the supposition that Black American culture is matriarchal. However, research suggests that this notion of a Black matriarchy is a myth. For example, Harrison (1977) has asserted that the highest concentration of underemployment in the United States is among Black women, and thus the notion that Black culture is matriarchial is not empirically substantiated. Furthermore, in research examining gender role stereotypes among Blacks and Whites, Smith and Millham (1979) found that the images of the "shiftless" Black male and the "matriarchal" Black female are not operative within contemporary Black America.

The myth may be perpetuated by the fact that Black women may appear stronger, more independent, more resourceful, and thus less "feminine" compared to middle-class Anglo women. Myth or not, describing Black culture as matriarchal has been a way to blame Black women for the problems that can be traced to slavery's destruction of Black social and family structures, which this country's long legacy of racism has compounded. According to Staples (1971), the notion that Black America is a matriarchy is a scapegoat tactic, and Black men as well as Black women have suffered as a consequence. As family breadwinners, for example, Black women have been accused of emasculating Black men (Schaffer, 1981).

Obviously, these aspects of gender and race should be understood so that, if and when they surface in the course of therapy, their significance will not be ignored. Similarily, therapists should be aware of general patterns that studies of Blacks in therapy indicate. For one thing, these studies show a general correlation between sex and the complaint diagnosis made.

In a survey of therapists asked about their Black patients, Jones and Gray (1984) note that Black men most often were diagnosed as having affective nonpsychotic disorders. Anxiety disorder was the second most frequent diagnosis. For Black women, the diagnoses were reversed. That is, anxiety disorder was diagnosed most frequently and affective nonpsychotic disorder was second.

Depression and work-related problems were the most frequent complaints cited by Black males, while Black females cited depression and family problems most often. Therapists said that their Black male patients experienced aggression passivity as the most frequent unconscious conflict and high-low self-esteem as the second. The order of frequency was reversed for women.

That self-esteem is a pervasive mental health issue for Black women has been well documented (Dansby, 1975). Indeed, among professional Black women, the issue of self-esteem has been tied to difficulties in relating to significant others (Bell, 1980). Finally, racism is one theme that is shared to the same degree by Black men and women throughout the therapeutic process (Jones & Gray, 1984).

The following case vignette illustrates some of the issues just described:

> Ann is a 25-year-old Black woman, whose physician referred her to an outpatient clinic after she was asked to leave her job. Employed as a nurse's aide in a general hospital for a year, Ann began having anxiety attacks and overate enough to gain 15 pounds in 2 weeks.
>
> Once in therapy, Ann vented her anger at her former supervisor, a White female, arguing that she was fired solely due to racism. She then became angry with her therapist, a Puerto Rican woman, because she did not know "what it's like to be a Black woman."
>
> Eventually, however, the therapist "proved" herself and Ann began to trust her. In therapy, she worked at controlling her temper and was able to obtain another job as a nurse's aide. During therapy it was revealed that Ann had a drinking problem, which was assessed and treated. (It has been reported that alcoholism among Black women is a special mental health problem resulting from their historical, racial, cultural, and structural position in the society [Smith, 1985]. In this volume, F.M. Baker further discusses alcoholism among Black women in her chapter on Afro-Americans.) Later, Ann began to talk about her boyfriend, outlining problems in their relationship. The therapist suggested couples treatment, to which Ann enthusiastically agreed. Ann's boyfriend, John, a 30-year-old unemployed Black man, expressed commitment to the relationship and willingness to participate in psychotherapy. The couple explored their relationship, including difficulties with their expectations of each other, and their roles within their respective families. They both completed treatment.

This case illustrates that the therapist's ethnicity and gender did not adversely affect her Black male patient's ability to engage in and benefit from therapy, denoting the egalitarian sex roles characteristic among Blacks. The therapist's ethnicity, however, did arise as an obstacle to trust in early sessions with her Black female patient. Themes of trust, racism, and Black women's pride pervaded the individual therapy. Themes of sexuality, marital expectations, and racism were present during the couples treatment. The therapist had to pay close attention to ethnic and gender differences so as to appreciate and then deal with their impact on the therapeutic process.

The Persephone Syndrome: Immigrant Greek Women. According to Welts (1982), the Greeks are family oriented, and their sex roles are highly stereotyped. Men are the providers and masters of their families, who expect to be obeyed by all members. They rarely assist in child rearing or household activities. In general, Greek men are observed to be authoritarian, sensitive to public opinion, and on guard against potential threats to their honor.

Women's roles are secondary to men's. In order for a Greek woman to be treated with respect, she must become the mother of a son. Only then will she achieve status or be considered trustworthy. This cultural dynamic is complemented by the Greek man's practice of worshiping his mother and taking care of her old age (Welts, 1982).

Greek wives are expected to follow tradition and, when marital conflict does arise, they rarely confront their husbands, but resist passively, often joined by their children (Welts, 1982).

Studies of Greek women emigrés to the United States show that they experience cultural traumas, one of which may be what Dunkas and Nickelly (1972) call the Persephone syndrome. In Greek mythology, the personalities of Demeter and her daughter Persephone were merged into one until Persephone married Hades and left for the Underworld. When they were separated, the mother–daughter personality split in two (Hamlyn, 1963).

In their study of 60 Greek females in long-term group psychotherapy, Dunkas and Nickelly (1972) noted symptoms of anxiety, depression, psychophysiological problems, and gross stress reactions after immigrating to the United States. According to the authors, the women's symptoms often represented guilt at leaving their mothers behind, that is, the Persephone syndrome. The therapy revealed their strong emotional attachments to their mothers and their attempts to reestablish union with them through psychological disturbance.

In the process of psychotherapy, Dunkas and Nickelly (1972) took into consideration the women's ethnic and sex role orientations. For instance, they encouraged a perception of the male therapist as a healer, and a figure of benevolent, paternal authority. They never raised divorce as an option, given the stigma that divorced women carry in the Greek culture. On the other hand, however, they did encourage the involvement of husbands in resolving the women's problems. And, in situations where marital

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reconciliation appeared impossible, the therapists did recommend separation. Eventually, the authors went so far as to challenge the stereotype of the mother in the Greek culture, even though the patients' strongest loyalty was to their mothers. This suggests that, once trust and rapport are established by recognizing and accepting the patient's native behavior and values, alternative behavior and values can be presented to the patient as options.

Marianismo ***and*** **Machismo:** ***Hispanics.*** Though most Hispanic ethnic groups have immigrated to the United States from a wide range of countries, they share a similar family structure and, in particular, clearly delineated sex roles that dictate gender behavior. Traditionally, the Hispanic family is patriarchal, with an authoritarian father, a submissive mother, and a mutual acceptance of this pattern. Throughout Latin America, San Martin (1975) found women's subordination to men's authority well accepted.

Traditional Hispanic women are expected to be sentimental, gentle, intuitive, impulsive, docile, submissive, dependent, and timid; men are expected to be cold, intellectual, rational, profound, strong, authoritarian, independent, and brave (Senour, 1977). This rigid demarcation of sex roles encourages a double moral standard for the sexes, exemplified in *marianismo*. Based on the Catholic worship of the Virgin Mary, who is both a virgin and a madonna, the concept underlying *marianismo* is that women are spiritually superior to men, and therefore capable of enduring all suffering inflicted by men (Stevens, 1973).

Taught to view the Virgin Mary as their aspiration, unmarried women are expected to be chaste and virginal and not to demonstrate interest in sex once they are married. When they become mothers, Hispanic women attain the status of madonnas and, accordingly, they are expected to deny themselves in favor of their children and husbands. In noting the high incidence of somatic complaints among low-income Hispanic women in psychotherapy, Espin (1985) suggests that these complaints may well be a reaction to the self-sacrifice dictum, especially since somatization is a culturally accepted mode of expressing needs and anxieties.

However, Stevens (1973) asserts that the *marianista* code rewards women who adhere to it. Because motherhood is sacred, women who bear children enjoy a certain degree of power despite the outward submissiveness of their behavior. Conversely, women who do not conform to the code risk social censorship. As a consequence, a dichotomous classification of women is reinforced, that is, the madonna–whore complex.

The counterpart of *marianismo* is *machismo*. This cultural sex role literally means maleness or virility, and its most salient characteristics are hyperheterosexuality and aggressiveness (Giraldo, 1972). *Machismo* also is manifested through physical dominance of women and excessive alcohol consumption. Furthermore, *machismo* dictates that the Hispanic male must constantly signal his sexually availability; seductive behavior is mandatory regardless of marital status (Sluzki, 1982). Paradoxically, the *macho* must protect his female relatives from the sexual advances of other men while making as many sexual conquests as possible. Though it has been argued that *machismo* is more prevalent among lower socioeconomic classes (Kinzer, 1973), it is nevertheless believed to influence behavior in all strata of the Hispanic society (Giraldo, 1972).

In the United States, Hispanic women are observed to defend and thus perpetuate *machismo* as a way of insulating the egos of their male relatives from the socioeconomic humiliations they suffer. For instance, Senour (1977) claims Chicanas reinforce *machismo* in their men to compensate for their lack of status in the Anglo culture. Similarly, Steiner (1974) cites Puerto Rican women who defend *machismo* as an understandable response to deprivation in the economic, social, and political spheres; men take their frustrations out on women because they cannot make their mark elsewhere.

All the same, traditional sex roles are undergoing change among Hispanic emigrés to the United States. For one thing, the emigrés native culture, including its *machismo-marianismo* percepts, is not reinforced by the new dominant culture, which, in fact, is prevaded by the impact of the women's liberation movement. Furthermore, cultural transition itself often presents Hispanic men and women with a sexual role reversal in terms of public life. In studies of recent immigrant families it has been observed that the family member who most often deals with the dominant culture assumes the instrumental role, thus becoming increasingly isolated (Sluzki, 1979). Not surprising, in many cases the instrumental role is filled by the male, the affective one by the female. Though this split between partners in cultural transition can result in mental health and marital problems (Canino, 1982), the division of labor, so to speak, is keeping with the traditional sex role expectations in Hispanic culture.

Instrumental-affective role taking is not always respectively male-female, however. The pressures of economic survival in the new culture, as well as the type of skills that are marketable, have caused a role reversal among Hispanics. In fact, this role reversal is by no means rare, as it is often easier for female immigrants to obtain employment in the United States than it is for males. Indeed, the woman may have no choice but to assume the instrumental role because she is able to sell her sewing and domestic skills while her husband's ability to farm does him no good in the city. Consequently, the Hispanic woman's access to and ability to come to terms with mainstream American society can be much quicker and easier than the man's. Unfortunately, however, the instrumental-affective role split between partners seems to be at least as divisive, if not more so, when the woman is on the instrumental side of the equation (Canino, 1982).

Sex roles among Hispanic women in the United States can be complicated (and confused) by the expectations imposed by the two different cultural contexts in which they live. The Anglo culture tends to apply masculine criteria to the evaluation of women, ascribing the greatest value to those who distinguish themselves occupationally or professionally. Yet this tendency is contradicted enough to send mixed messages to the female. Consequently, for example, the Chicana is far surer of her role within the traditional Mexican-American culture than she is in the mainstream, where her role is ambivalent (Senour, 1977). Apparently, this sureness of role that her native culture provides has not stopped the Chicana, nor other Hispanic women in the midst of cultural transition from exploring the behavioral alternatives available to her. This experimentation can lead to conflict within the nuclear unit as well as within the extended family.

The clinician working with this population needs to be attentive to all of these issues and to recognize that the clear-cut demarcations between the sexes in traditional Hispanic culture may affect therapist-patient relations. Padilla (1981) states, for example, that some Hispanic male patients have trouble discussing their sexual concerns with female therapists; conversely, most Hispanic women prefer to discuss their personal problems with a female (Hynes & Werbin, 1977).

The following case vignette illustrates some of the issues just discussed.

> Olga is a 39-year-old Colombian woman who immigrated to the United States when she was 11 years old. She grew up with her mother and two sisters; her father stayed in Colombia. She finished high school with honors and planned to finish college when she met Rafael, a 32-year-old Puerto Rican, who migrated to the mainland when he was 21 years old. At age 21, Olga married Rafael and dropped out of college after 6 months. The couple has three children, and both work in a factory, where Rafael is an inspector. The family initiated their contact with the mental health system when their youngest child exhibited behavioral problems at school. The child began to receive psychological help and the school social worker recommended that Olga also seek treatment because she was too "nervous."
>
> Interviewed at a community mental health clinic, Olga complained of nerves, headaches, sleeping difficulties, and lack of appetite. No previous mental health problems were acknowledged. Assessment revealed that she was suffering from a reactive depression due to the family situation, and particularly, to the state of her marriage.
>
> Rafael, her husband, was invited into the clinic to facilitate the evaluation of Olga. A male and a female therapist team conducted the session. Rafael complained that his wife was not being a "good mother" and thus was responsible for their child's problem behavior at school. In turn, Olga

argued against what she called Rafael's rigid view of her role as mother and wife. The couple's conflict over what constitutes the appropriate role of a wife and mother originated approximately a year after Olga began working outside the home.

During this session it became apparent that Olga was more acculturated to the mainstream culture than her husband. She was fully bilingual while he was not; and she espoused more egalitarian sex roles than Rafael. The couple was advised to undergo therapy together, but Rafael declined. Olga decided to continue individual treatment.

Individual sessions focused on Olga's feelings and the symptoms experienced in reaction to her family and marital situation. As some of these symptoms abated, she reported that Rafael was becoming more irritable at home. Although she did not articulate feeling responsible for the situation, she considered the possibility of resigning her job in an attempt to neutralize the conflict. After 3 months of therapy, Olga revealed that she suspected her husband of having an affair at work. She added that they were having heated arguments at home, but that he denied having an affair. Olga asked her husband to attend therapy with her, but reported he said: "I do not have to account to anyone for my actions, especially not to women."

Olga continued therapy, but there was no progress. She considered several courses of action, including resigning her job, asking for a legal separation, and leaving for Florida, where one of her sisters lived. However, she remained undecided until, late one night, accompanied by a female coworker and under the influence of alcohol, Rafael had a car accident. The incident prompted Olga's decision to seek a separation.

One month later, Rafael contacted the male clinician, who had conducted the couple's evaluation, and asked for an appointment. Rafael told the clinician that he would like to enter into treatment with Olga, if she was still interested in doing so. Olga agreed to attend treatment, although she claimed she was pressured into it by her family as well as Rafael's.

After several sessions with the whole family, marital treatment centered on the couple's changing gender expectations and the renegotiation of their roles. The fact that Olga was coping with conflicting sex role expectations ("Hispanic at home, Anglo at work") was taken into account by the male and female team who worked with Olga and Rafael for 3 months. Unfortunately, the couple discontinued treatment once it became apparent that Rafael had a drinking problem but refused to attend an alcohol rehabilitation program.

This clinical vignette demonstrates the pervasive impact of clearly demarcated sex roles in traditional Hispanic culture. Rafael demonstrates the strength of these expectations in his dissatisfaction with any behavior of his wife's that does not conform to his gender code. Conflict between the couple heightened after Olga began working in the factory; on the one hand, this threatened Rafael's concept of what a wife and mother should be; on the other, Olga experienced confusion in coping with the conflicts between what was expected at home (Hispanic) and at work (Anglo). Rafael's refusal to enter couples therapy and his disparagement of disclosure to a female therapist also reflect his strict separation of the sexes into certain prescribed roles. Conceivably, his alcohol problem was symptomatic of frustrated *machismo* vis-à-vis his wife as well as a reaction to the broader scope of frustrations seemingly inherent in cultural transition.

More accustomed to the United States, Olga expressed interest in adopting some of the behavioral options of her Anglo counterparts. However, this put strain on her relations not only with her husband but also with her extended family. The difficulty of meshing her Hispanic heritage with those aspects of the mainstream that attracted her was a major source of emotional distress.

Here the therapists had to act as cultural mediators between two people with differing levels of acculturation to the mainstream. The couple's cultural differences created conflicts in the expectations of themselves and each other. The therapists needed to sort out and identify these cultural differences before they could begin to address the problems that flowed from them.

FUTURE DIRECTIONS: TRAINING AND RESEARCH

The phenomenon of cross-cultural transition can raise a host of mental health problems. If the phenomenon goes unrecognized, these problems go untreated, and they can undermine whatever else the patient and clinician have found to bind them together in a therapeutic relationship. Fortunately, the mental health profession is beginning to recognize the need to understand cultural transition and the values of a variety of cultures as part of practitioner training. Training in cultural diversity is currently being proposed as a goal by several professional associations within the mental health field. The American Psychiatric Association, for example, has established a Task Force on Multiethnicity and Cultural Psychiatry. It is the mandate of this task force to increase awareness and understanding of the variety of cultural and ethnic backgrounds within our pluralistic society, and to advocate diagnostic and treatment techniques specifically geared to particular ethnic groups (Foulks, 1982).

In 1985, the American Psychological Association reorganized its temporary Task Force on Minority Education and Training into a permanent

Committee on Ethnic Minority Human Resources Development. Like its psychiatric counterpart, this committee advocates training in cultural diversity as a prerequisite to providing psychological services to ethnic minority populations. In order to accomplish this, the committee has presented to the association a position paper urging that multicultural awareness be added to the criteria used to define the philosophy, goals, and requirements, curricula, praçtica, and composition of training psychology, just as scientific rigor and clinical expertise currently are used (Committee on Ethnic Minority Human Resources Development, 1985).

Still, the precise professional qualifications necessary to work in a multicultural environment have yet to be defined (Pedersen & Marsella, 1982), though attempts to identify them have been made. As a preliminary, Ridley (1985) presents what is currently being done and what needs to be implemented for the development of psychology programs that have ethnocultural relevance.

Current Praxis

1. ***Ethical Imperative.*** Treatment of culturally different patients by professionals lacking training in cultural diversity is unethical.
2. ***Cultural Context Imperative.*** All mental health practice occurs in a cultural context.
3. ***Legal Imperative.*** Professionals who treat culturally diverse individuals without duly certified cross-cultural credentials effectively violate their patients' civil rights.

Needed Implementations

4. ***Demographic Imperative.*** The cultural diversity of mental health professionals should correspond proportionately to the cultural diversity of the society.
5. ***Scholarly Imperative.*** Cross-cultural mental health treatment must be recognized and legitimized by academia.

Ridley concludes that, although several training modules have emerged, a conceptual, programmatic framework is still needed to develop cross-cultural training in mental health as a discipline.

Though cross-cultural training is not yet a well-defined discipline within the context of mental health, some of the necessary training components are apparent. These components are (1) didactic, (2) clinical, and (3) empirical.

The didactic or teaching component should include incorporating into the curriculum case histories and other readings on each ethnic group studied, which illustrates migration history, demographics, cultural values, family structure (i.e., sex roles), belief systems, personality development, and relations with the dominant culture.

Once trainees have obtained this theoretical knowledge, they should begin to examine each ethnic group's definition of mental illness, health-seeking behavior, treatment expectations, and attitudes and expectations toward mental health practitioners.

The second or clinical component should be a mandatory adjunct to the intellectual foray into the culture that the students have made through readings and lectures. Leighton (1982) proposes that cultural training be built into the clinical rounds made by psychiatric residents, who would be required to treat patients from ethnocultural backgrounds different from their own. The ideal here is to enable the residents to identify their own ethnocultural bias and to become sensitized to cultural differences, presumably only read about; sensitization would be the first step in developing clinician-patient rapport.

The third or empirical component of cross-cultural mental health training differs from the clinical component in that the students' focus is turned inward. Pinderhughes and Pinderhughes (1982) advocate the participation of psychiatric residents in short-term sensitivity groups in which they explore and discuss among themselves their own ethnic backgrounds, as well as the assumptions and stereotypes they attribute to other ethnic groups.

The author's own experience in training practitioners in a cross-cultural mental health clinic was characterized by a combination of all three components. The educational component consisted of teaching a seminar on ethnic minority issues in mental health based on the specific ethnocultural backgrounds of those patients using the clinic. The cross-cultural encounter between clinician and patient was analyzed in terms of special issues, such as transference and countertransference, as well as in terms of the basic therapist-patient dyad. Finally, the clinicians in training discussed with each other their own backgrounds. This experience increased their awareness and sensitivity to cultures other than their own, and led them to call on each other as resources and consultants in the course of clinical practice.

Cross-cultural mental health training is not only useful where racial and ethnic differences exist between patient and clinician. For instance, cross-cultural treatment methods also are needed when the clinician and the patient are racially and ethnically similar but have different socioeconomic backgrounds and/or different value systems, sex role orientations, religions, and educations, and/or when there is a significant difference in their ages (Atkinson, Morten, & Sue, 1979). As a practical matter, then, virtually all clinical practice can be said to be cross-cultural in nature, and, therefore, all clinicians stand to benefit from cross-cultural training.

Furthermore, Pedersen (1981) suggests indirect social benefits from cross-cultural psychotherapy. In his view, the culture of the future is analogous to a foreign one, requiring similar patterns of adjustment and adaptation, and in fact any new situation, such as new employment, requires us to adjust our roles as well as identities. Thus, Pedersen suggests that the knowledge we are developing to treat its impact on mental health can be applied to help us all adjust to inevitable change.

Research in cross-cultural mental health is another area that demands the highest priority. As Kagehiro, Mejia, and Garcia (1985) so eloquently argue, failure to investigate and incorporate the effects of culture and ethnicity into mental health research results in limited understanding of human behavior.

Historically, research on ethnic minority populations in the United States has been divided into three categories: (1) the inferiority model, where the groups have been identified as socially and intellectually inferior to the dominant group; (2) the deficit model, where the plight of the ethnic groups has been attributed to social conditions; and (3) the bicultural or multicultural model, where the variables of an ethnic group's culture and those of the majority group's are considered interactive and not independent (Sue, 1983; Sue, Ito, & Bradshaw, 1982).

The historical studies cited here are broad, if not sweeping, in their conclusions. What becomes evident is the need to enlarge the number of variables studied in order to obtain more detailed results. To mention just a few, the following considerations should be undertaken in cross-cultural mental health research: developmental stages of ethnocultural identity; ethnic concepts of mental health and illness, for example, attitudes and expectations about mental health care, and culture-specific syndromes and their treatment; effects of cultural transition on behavior and ethnocultural identity, for example, adaptive cultural behaviors, and resilience versus risk factors among different ethnocultural groups; effects of biculturalism and multiculturalism on mental health; analysis of the therapist–patient dyad, including ethnocultural similarity and dissimilarity; the cultural relevance of different therapeutic modalities; and psychotherapeutic process and outcome studies.

Effective cross-cultural mental health research obviously also depends on continued improvement in the development of theoretical models. According to Draguns (1981) these models need to include sensitivity to the interaction of ecology and human behavioral problems, to competence building, and to the healing and helping processes.

Sue and his colleagues (1982) have developed a research model in ethnic minority mental health that can be applicable to cross-cultural mental health as well. First, the authors propose an increase in the quality and quantity of the research; second, an investigation of the etiology of mental health and illness; third, identification of a methodology relevant to the delivery of mental health services; and, fourth, implementation of the research findings.

Other researchers note the need to evaluate and rate the relative effectiveness of traditional research design. Much of the research in cross-cultural psychotherapy has involved survey or analogue research designs, which, as Atkinson (1985) points out, have their limitations. For example, subjects in analogue and survey studies of ethnic and racial issues usually are aware of the variables studied. Atkinson believes that greater credence should be given to the results of archival studies where participants generally do not know they are being studied.

CONCLUSIONS

Cross-cultural mental health treatment is recognized more and more as a bona fide specialty area. As our society becomes increasingly pluralistic, mental health practitioners who can competently address multicultural contexts may well be very much in demand.

Cross-cultural mental health treatment can be used in a wide range of circumstances. The treatment techniques can be effective not only in helping the patient through the crisis of cultural transition but also in healing a chronic illness with its source in a certain culture. Sensitivity, understanding, and competence in multicultural contexts benefit not only the culturally different patient but the clinician as well. Indeed, cross-cultural mental health treatment techniques may be useful even when the patient and clinician share the same race and ethnic background. Given the inevitability of differences between patient and therapist, virtually all clinical practice can be seen as cross-cultural in nature. Therefore, a clinician competent in cross-cultural issues is indeed a competent mental health practitioner.

As clinical training, practice, and research in cross-cultural mental health continue, we can expect to see advances in our understanding of the relationship between culture and mental health. Those techniques we develop to cope with individual cultural transition and life in a multicultural setting may translate well to the general human endeavor of adjustment to constant change.

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— CHAPTER SEVEN

Afro-Americans

F.M. BAKER

HISTORICAL PERSPECTIVE

This chapter will focus on Black Americans who are Afro-Americans. Their forefathers were Africans, predominantly from nations in western Africa. They lived in tribal communities, where the values of family and the good of the community were emphasized (Pinderhughes, 1982). With the economic exploration of the North American continent, a variety of ethnic groups were used as slave labor. When Africans were found able to survive the environment and the labor of the plantations in North and South America and the Caribbean, they became the primary focus of the slave trade. Following the Civil War in the United States, the progeny of these Africans fought to obtain an equal place in American society.

As the decades passed, immigrants from Ireland, Italy, China, Hungary, Puerto Rico, Cuba, and Southeast Asia arrived in America and displaced Black Americans from jobs. Although African values remained the bedrock of the Black community, the devaluation of persons of African heritage continued to exist as a pervasive, institutionalized pattern of American culture. For many years the history of Black persons was depicted as beginning with slavery in the continental United States. When African culture was discussed, it was characterized as primitive and noncontributory to the development of civilization. Africans, with a history of more than 3000 years (James, 1954), were stereotyped as childlike persons who were illiterate and without culture. This pervasive stereoptyping of the "Negro" in literature and the media was directly and forcefully confronted during the Black revolution of the late 1960s and the early 1970s. Subsequently, the images of Afro-Americans portrayed by the media as well as information presented in a broad range of textbooks (Romero, 1969; Salk, 1967), presented the continuity of their culture as well as their rich heritage (Haley, 1976).

The term *Afro-American* is used here to convey the combined heritage of Black persons in America. But that cultural heritage may have a further mixture including Caribbean (West Indian), Native American, and northern European components. Working with persons who appear "Black," it is important to establish the specific heritage within the individual's family of origin. Although there are areas of similarity in perspectives and expectations across these groups, there are many areas that are dissimilar. Therefore, in order to have a context for understanding the behavior, defenses, expectations, vulnerabilities, and anger of Black patients, it is important to ask patients to describe their heritage and the cultural background of their parents and grandparents. This chapter, then, will focus on problems that arise in the psychiatric treatment of Afro-Americans.

DEMOGRAPHIC DATA

The inaccuracy of the United States Census data on Blacks has been acknowledged to be due to the failure of Black persons to respond as well as to the enumerators' fear of urban neighborhoods. Nevertheless, certain data merit presentation here, in spite of this limitation.

In 1980, Black Americans comprised 12 percent (26.5 million individuals) of the United States population. Fifty-three percent of Blacks were female and 47 percent were male. Forty-four percent of Black women were in the childbearing years, between age 15 and 44. Although Black males outnumber Black females through age 19, the loss of Black males begins in the age 20–24 category, with a significant difference noted in the 40–49 age group. This sex difference is sustained throughout the life cycle. Some 29.9 percent of the Black population were below the poverty level compared to 9.4 percent of the White population.

The average number of persons per Black family was 3.72; per White family it was 3.9. In the Black population there were 1,568,417 female-headed households without a husband present with children under age 18. For Whites, 3,166,397 resided in female-headed households without a husband present with children under age 18. Although it is often presented as a concern in the Black community, Whites have three times the single-parent households of Blacks.

Knowledge of these demographic data provides an important context for the therapist. The middle-aged male who grieves over the loss of his teenage "buddies" and the young adult Black female who bemoans the absence of male partners are discussing the personal reality of the census data. Although emphasized, female-headed households are *not* the majority family structure in the Black community and are related to socioeconomic level. Finally, particularly in teenagers and young adult patients, the presence of the risk of violence (suicide or homicide) as an ongoing threat to life can be a daily reality. The therapist should be aware of this chronic tension as another etiology of self-medication with drugs that are not always obtained legally.

THE BLACK FAMILY

Several authors have debated the structure and function of Afro-American families, and Mullings (1985) provides an excellent review of their different perspectives.

Moynihan (1965) characterized Black families as a tangle of pathology due to their matriarchal structure. As noted by Bell, Bland, and Houston (1983), sociological and psychological analyses of the Black family have frequently led to the erroneous premise of a matriarchy within the Black community. Consequently, Black women have been seen as unfeminine, castrating to their men, promiscuous, and commonly on welfare. In turn, Black men have been characterized as inadequate father figures and as emasculated men unwilling to provide for their families. Other authors countered this characterization of Black families by identifying the racism within American society that restricted education (Hill, 1971; Pinderhughes, 1982), employment, and housing opportunities for Black Americans and assigned many to an underclass existence that produced aberrant behaviors.

The importance of the family within the Afro-American community has evolved as part of the African heritage. In addition to community welfare as opposed to the welfare of the individual, African cultures emphasized the importance of children; the grandchild was the fruition of the grandparents' generation. The birth of grandchildren ensured the continuity of the family (Wylie, 1971). In contrast to many northern European Americans, the Afro-American family is an extended family including nonrelated persons (adults and children) who have been adopted or absorbed into the family unit (Martin & Martin, 1978).

Although chattel slavery separated parents and children by auction and by death, family units comprising biologically related and nonbiologically related individuals formed to provide support, care, and comfort for their members as well as survival skills and key information (Gutman, 1976). These units survived slavery and continued during the period of reconstruction (Johnson, 1982). Similar patterns are seen today in the extended family units that are found in Afro-American communities (Martin & Martin, 1978; Stack, 1974).

Hines and Boyd-Franklyn (1982) reported that the Black extended family provided important intergenerational support. Elder grandparents and similar-aged individuals provided the wisdom of their years of experience, maintained a favored role as the family historian, and were productive and useful members (Baker, 1982; Seiden, 1981). Their children continued some of the traditional foci of the prior generations and began to develop their own approach to a variety of situations.

Davis (1968) discussed the role of the family in developing an adequate identity. She emphasized the importance of the family in providing a series of networks of self-support and stressed the importance of identifying the patterns of familial interactions. Although some authors described the pathology of Black families (Moynihan, 1965), other workers (Hill, 1971; Hines & Boyd-Franklyn, 1982; Johnson, 1982) have emphasized the strengths of Black families, the extended kinship network, and the adoption mechanism that provides financial and personal resources as well as role models. Thus the therapist focusing upon the nuclear family may miss important figures of support and authority in the extended family of the Afro-American. Further, the tension in the relationship of a couple may reflect ambivalence or animosity between one partner and the adopted mother of the other partner who may not be a biological relative.

Hines and Boyd-Franklin (1982) and Lewis (1983) reported on egalitarian relationships within Black families. Since Moynihan's initial publication in 1965, the concept of the Black matriarchy has been well identified as a myth. In Lewis's sample of well-functioning, working-class Black families, the families were slightly above the poverty level. In addition to the extended family network, church and scouting were important outlets and avenues of socialization for the family members. Too often the confounding influences of racism, social status, and poverty have not been noted (Pierce, 1970, 1974). When survival becomes the focus of family life, Lewis (1983) found that Black families moved toward a more rigid role definition with the stronger partner, more usually the male, setting family policy and making decisions.

What of the single-parent families? Here, also, the extended family played a moderating role (Hill, 1971). Alternative care givers for the child, and respite for the mother, as well as emotional support and financial assistance can be provided by extended family members. The pregnant teenager has remained within the Black family (Hill, 1971), not ostracized even when there were strong cultural taboos against out-of-wedlock pregnancies in American society.

Pinderhughes (1982) has discussed the consequences of the victim system—particularly upon the Afro-American male. Unable to find employment to support his family due to limited education in a system that fulfills its prophecy of his failure (Rosenthal & Jacobson, 1968), the Black male may become negative, irresponsible, manipulative, exploitative, violent, remote, or absent. In this situation, if the mother cannot assume a strong role, the family is in serious trouble. In a family beset with financial and personal crises, with the woman as the only available parent, her role may become exaggerated and she may become the pathway for all family interactions, with the result that the children then respond to the mother's mood and wishes rather than to their own needs; and the mother relates to the children as a fused group (Hines & Boyd-Franklin, 1982; Pinderhughes, 1982). Interactions and relationships with uncles, cousins, grandparents, or the "church mother" may refocus the mother–child interaction and provide alternative significant others for both mother and child (Martin & Martin, 1978).

The therapist must appreciate the resources within the Afro-American family and mobilize them to provide effective care for the Black patient. Both the single-parent family and the working-class Black family as well as middle-class Black families may have a network of extended family members who can provide emotional and financial support in a crisis. In some cases part of the therapeutic intervention is the remobilization of this extended kinship network. Other important supports exist within the Black community. (The role of religion and the Black church is discussed in Chapter 3 of this volume by Griffith & Young.)

ISSUES IN CLINICAL PRACTICE

Socioeconomic status may influence the individual's access to psychiatric services. The Black patient's knowledge of available services is influenced by life experiences and family comments. The history of racism in America is presented today in the stories of Black grandparents about segregated facilities, the loss of life on the way to the "Black" hospital, and the hostility of health professionals to Black patients. As most Black persons have experienced some negative interaction based only upon their skin color, the reception that a Black patient may receive in a specific setting remains an uncertainty. This often produces an anticipatory anxiety in Afro-American patients as they approach a health care institution (community mental health center, community clinic, or general hospital) or a private practitioner. As noted by Bell and colleagues (1983), Black patients can be defensive, hostile, and nonverbal (in an initial meeting in a new setting), thereby adapting to powerlessness. They often experience fear and distrust of the White therapist. If Black patients believe the goal of therapy is to maintain the status quo and their place in society, they may be suspicious of the motives of Black as well as White psychiatrists.

Adams (1950) discussed countertransference and transference in the context of a segregated society. He emphasized [illegible] the environmental covenants (segregated facilities and housing) and the narcissistic injury for Afro-Americans that results from prejudice. For the White therapist he commented about feelings of perplexity and uncertainty in the presence of a Black patient. Further, he warned of the danger of the White therapist and the Black patient focusing upon their differences. In 1950, the feelings of aggression and hate experienced by a Black person were concealed in an attitude of submission and subservience. Feelings of insecurity in White therapist related to (1) the physical appearance of the Black patient, (2) therapists' unfamiliarity with Afro-American culture and problems, and (3) even doubt concerning the patient's ability to pay. In an effort to conceal their insecurity and guilt feelings, therapists unwittingly may be oversympathetic and indulgent or may be patronizing or hostile. The therapist's greatest danger may be a tendency to oversimplify and ascribe all problems of Black patients to cultural and racial conflict. Such a response from the therapist signals to the Black patient the ambivalent racial attitude of the therapist, and this results in the effective thwarting of the formation of a therapeutic alliance. The Afro-American patient should be able to expect, minimally, a neutral environment in the clinical setting.

Jones, Gray, and Jospitre (1982) reported on a mail survey of psychotherapists who treated Black men. Psychiatrists treating Black male patients reported the following factors as the most important in successful treatment of Black males: empathy; patience; supportiveness; tolerance; and the ability to listen and indicate directions without leading. These therapists also noted that the racial issues must be put in perspective, that the therapist must be knowledgeable, and that the therapist must gain the patient's trust.

Although the civil rights movement and the Black revolution of the 1960s removed many overt barriers of segregation and confronted the covert barriers within institutional settings, the myths that Black Americans were welfare mothers, underachievers, and marginal persons in pathological families continue in the 1980s. A Black man or woman entering psychiatric treatment expects the therapist to have some knowledge of the implications and effects of racism upon Afro-Americans in American society. The therapist should listen with an attentive and critical ear to the issues, incidents, and experiences that brought the Black patient into treatment. This facilitates the development of a therapeutic alliance in which the patient is accepted as a worthwhile human being, who with support and understanding can address the dysfunctional adaptive styles, destructive defenses, or the loss of contact with reality that brought him or her into treatment. If a Black patient feels rejected or devalued by the therapist, he or she is likely to discontinue the treatment.

Although it is helpful if the therapist is Black because the therapist can serve as a role model, this is not necessary to accomplish the therapeutic task. What is required for successful psychotherapy with a Black patient is empathic, sensitive, and inquiring concern. This point has been emphasized by several authors (Bell et al., 1983; Bradshaw, 1978; Brantley, 1983; Spurlock, 1982). Adebimpe (1981) cautioned that disparities in background between therapist and patient can result in errors of data collection due to differences in vocabulary, modes of communication, value systems, and expressions of distress.

The strength of the extended Black family and the institutional racism manifested by American society pressured the Black family into tolerating unusual behavior. It has been reported that Black persons did not suffer from mental illness during slavery because of the protective nature of chattel slavery (Bevis, 1921; Malzberg, 1963). Historically, Afro-Americans were excluded from the health care system and depended upon indigenous healers. Prudhomme and Musto (1973) noted that the low insanity rate for Blacks was often interpreted during the nineteenth century as a result of the comforts of slavery or the dull strength of the uncivilized.

When the tolerance threshold of the family or the community was reached, Black persons were brought to a medical facility for evaluation. As payment issues continue to be determinants in the locus of provision of care, a significant proportion of Afro-Americans were treated in state hospitals or other public facilities. The family and significant others expected the patient to be gone a long time and, if released, to be "different"—not necessarily well. Mental illness was described as someone's "going off," and there was little recognition and understanding of the range of psychiatric illness, that is, depression, psychosis, personality disorders, substance abuse, and organic brain syndromes. The geographical location of the patients also influenced their entry into treatment. Psychotic delusional behavior was tolerated less in a small apartment in a housing project than in a rural farming community. Thus the definition and identification of mental illness were narrowly focused, and treatment was the "warehousing" of the patients.

In the 1960s, civil rights leaders emphasized the positive aspects of Afro-American culture and the longitudinal history of Black Americans. Such leaders confronted the institutional racism that stereotyped Black

Americans, restricted their life options, and directed Blacks into second-rate career paths, residences, and health care systems (Wilcox, 1973). The significant improvement in self-image for Black Americans resulted in more assertive behavior and in increased expectations. With the introduction of neuroleptics and antipsychotic medication in the late 1950s, the treatment of psychotic symptoms was revolutionized (Langsley, 1985). The length of stay in treatment facilities was significantly reduced, and alternatives to the large state hospitals were explored. The initiation of federal funding to build mental health treatment facilities within local communities then centered psychiatric services in the community. The increased visibility of mental health facilities and specific outreach programs to service Black populations increased the knowledge within the Black community about psychiatric symptoms and treatment options. With community participation mandated on the boards of these facilities, community leaders became active participants in policy decisions. Although the degree of effective particpation varied from center to center, the Black community through its leaders participated in discussions that defined illness, addressed the various treatment modalities, and assessed outcomes (Bragg, 1982).

With their increased expectation of institutions, Afro-Americans sought help at the CMHCs and sometimes demanded aid that psychiatry could not provide. Clarification of the "walk-in customer's" request became an important task for triage personnel (Lazare, 1972, 1975). Psychiatry could treat specific psychiatric illness, but its ability to influence social welfare legislation and housing codes was based on the individual votes of psychiatrists, not on their skills as physicians. The advisory councils of CMHCs served as a community nucleus to address these social and economic factors that are significant environmental stressors for poor Afro-Americans (Bragg, 1982).

The deinstitutionalization of state hospital patients was catalyzed by several factors, among which were the use of neurolepics and the existence of CMHCs. A long-absent family member returned home to receive treatment locally at a CMHC, possibly with instructions to continue taking medication. It was often unclear whether the illness was cured or in remission and what the patient's significant others could do to maintain the well-being of the patient. There was significant anxiety about the potential for unusual or violent behavior and concern about the true availability of CMHC staff. Black patients without extended family and difficulty with treatment compliance joined the number of homeless persons in our cities. In the world of homeless people, it is suggested that between 25 and 50 percent have serious and chronic forms of mental illness (Arce & Vegacre, 1984).

Today, 10 years down the road, American society is discussing mental illness openly. Some private psychiatric hospitals advertise their treatment of depression and alcoholism. Political, movie, and sports personalities reveal their personal histories of psychiatric illness and treatment. There is an increasing understanding by many Black Americans that specific behaviors are signs of mental illness and that treatment can be sought at the general hospital and CMHC as well as at the area state hospital. The family member is expected to return home improved and continue treatment locally at a CMHC. For patients with recurrent illness who are noncompliant with medication, their families complain that they are released too soon. When the family as well as the patient is involved in the treatment plan, treatment compliance and realistic expectations of care are defined effectively for all and better compliance is obtained (Jones & Seagull, 1977).

The treatment compliance of Black patients is influenced by the quality of the interaction between the therapist and the patient (Bragg, 1982). The ease of psycholinguistic communication, the mutual understanding of cultural references, and the avoidance of confounding the transference-countertransference issue with ethnocentrism (racial stereotyping) will facilitate the formation of a therapeutic alliance. Although this type of interaction is facilitated by a Black therapist and positive role modeling is possible, the therapist can be non-Black, effective, conversant with cultural themes, and knowledgeable about the historic context of Afro-Americans and psychotherapy.

CLINICAL PRACTICE

Before discussing specific psychiatric illnesses in Black populations it is important to review the historical problem of psychiatric diagnoses in Black patients. Bell and colleagues (1983) summarized the myths and stereotypes that resulted from racism and influenced diagnoses, treatment, and research decisions. From the early notions about the biological inferiority of Blacks, the period of reconstruction saw the falsification of census figures to reflect an increased incidence of mental illness in Blacks who had "lost the benefits of slavery" (Deutch, 1944). In the early 1900s Blacks were characterized as "too emotional, sexually promiscuous, lazy, in need of authority, criminally inclined, and unintelligent" (Bevis, 1921). During slavery there was no provision for mentally ill slaves. When mental hospitals were established in the 1800s, only a few northern facilities admitted Afro-Americans to segregated units. The majority of psychiatrically ill Black persons were admitted to almshouses or placed in jail (Prudhomme & Musto, 1973).

In the 1900s differences in diagnostic patterns between Black and Whites were noted. Cannon and Locke (1976) analyzed admissions to state and county hospitals. They found that White males were diagnosed with alcohol disorders while Black males were diagnosed as schizophrenic. When discharged diagnoses from general hospital inpatient services were reviewed, the predominant discharge diagnosis observed in both Black males and Black females was schizophrenia, and in White males and females the discharge diagnosis was depressive disorder. The international studies of schizophrenia identified the overdiagnosis of schizophrenia by United States psychiatrists (Cooper, Kendell, & Gurland, 1972).

Owing to racial biases in diagnoses, Blacks were more likely to be diagnosed as schizophrenic (Evarts, 1914; Fisher, 1969; Frumkin, 1954). Unfortunately, reports by several authors over the years emphasized that Afro-Americans either were too inferior [illegible] the intrapsychic framework to become depressed (Wilson, 1957). [illegible] resulted in a misdiagnosis and underdiagnosis of affective illness in Black persons. Recently, other authors have presented evidence to dispel this erroneous assertion about Afro-Americans (Bell & Mehta, 1979; Helzer, 1975; Jones, Gray, & Parson, 1981).

Black Suicide Attempters

A suicide attempt has been defined as "an intentional self-inflicted injury (including ingestion), unless there is strong evidence both in circumstances and in the patient's statements that there was not even any partial ambiguous self-destructive intent" (Weissman, Paykel, French, Mark, Fox, & Prusoff, 1973). Suicide is defined as the intentional self-termination of one's life. Prudhomme (1938) provided the first discussion in the literature of suicide in Afro-Americans. Having discussed the intrapsychic conflicts existing for the Black American whose physical characteristics were labeled as "bad" by the majority groups, Prudhomme noted that the number of actual suicides among Negroes was unmistakably smaller than in Whites and the number of attempts at suicide among Negroes was proportionally as great as or even greater than in Whites. The Negro was considered a neurotic group, this neurotic state being brought about through a system of inhibition and repression (Prudhomme, 1938). He reported that the lower incidence of completed suicide was due to factors such as the restricted access to economic opportunity, rural living, and group solidarity facilitated by racism. Several decades later, Hendin (1969) studied a New York sample of attempters. He emphasized the roles of tenement living, economic exclusion, and racism in the etiology of suicidal behavior by Black young adults. In a sample of Black suicide attempters studied in Newark, New Jersey, Kiev and Anumonye (1976) found interpersonal discord in the context of alcohol abuse as a precipitating pattern. Poussaint (1975), Christian (1977), and Davis (1979) all emphasized the usually lower suicide attempt rate in Black women. Factors that helped to explain this low incidence included the Black family, the

Black community, and the Black church. These institutions provided support to persons alienated from society with few options for activities and experiences to enhance self-esteem. Apparently, these options were not utilized by Black males or were more readily utilized by Black females.

The effect of psychosocial tension and economic stressors upon the Afro-American life cycle has been discussed by Baker (1987). Owing to the self-fulfilling prophecy of school failure (Rosenthal & Jacobson, 1968), economic options are narrowed in late adolescence, and Black teenagers and youth are thwarted in their adult development. Alternative and aberrant routes, such as street life and teenage pregnancy, result in individuation from the family home and establishment of their own residence. If young Black males are caught in the quagmire of the street, the rage of being excluded from the mainstream of American life and being powerless in the broader society may erupt in violence. If this violence is directed toward the self, a suicide attempt results. If directed toward others, Black-on-Black homicide results (Poussaint, 1975). If the Black males survive, they may be caught in an illegal act resulting in incarceration and the possibility of spending 10 to 25 years in jail (Baker, 1984, 1985).

In a recent review of Black suicide attempters in New Haven, Baker (1984) found that Black women who attempted suicide were single, stressed, had had an argument with a significant other, and their self-injury was an impulsive act. Although similar in marital status, precipitants, and impulsivity to White female attempters in this sample and in the literature (Weissman, 1974), the suicide attempt rate for Black females was 11.88 per 100,000 compared to a White female rate of 41.43 per 100,000 for the New Haven Standard Metropolitan Statistical Area. Black males in her sample were older, had a prior psychiatric history, were in ongoing treatment, and had more severe psychiatric diagnoses. Both Black male and Black female suicide attempters had an increased history of psychiatric treatment; 76 percent of males and 64 percent of females had had prior treatment. Thirty-five percent of males and 54 percent of females had made a prior attempt. This study raised specific questions regarding suicide attempters in general and Black suicide attempters specifically. In her recent review of the literature on Black suicide, Baker (1987) emphasizes the increased risk for poor Black adolescents who are only marginally involved in society due to school failure or inability to obtain employment. Specific recommendations and primary preventive strategies are included in that report.

As the locus of psychiatric care moves to the general hospital, CMHCs, and emergency rooms due to deinstitutionalization, are the patient populations in these settings changing? Is a greater percentage of patients in current treatment or are persons who have had prior psychiatric treatment attempting suicide and seeking care in these settings? Are the diagnoses of suicide attempters becoming more severe? Is the proportion of attempters with no prior psychiatric contact or psychiatric treatment history declining? Further studies of suicide attempters, evaluated in various settings, are indicated to clarify these points. Additional replication of Baker's findings in other settings is needed before generalizations can be made. Recent studies in both Black and White attempters (Task Force on Youth Suicide, 1987) confirm an increase in attempts by persons aged 20 to 24, particularly in White males (Bogard, 1970) and Black males (Frederick, 1978).

Specific treatment strategies for Black suicide attempters were presented by Baker (1984). Recognizing the need to clarify the diagnoses based upon the assessment of the patients, and, if available, past symptoms from an old medical record or family member or friend, a current diagnosis should be developed. Suicide is a life-threatening behavior. It is not a psychiatric diagnosis, but rather the manifestation or result of a specific psychiatric disorder. A change in the patient's diagnosis based upon current assessment may be an important and significant intervention in view of the treatment implications for different diagnoses. As noted in Baker's sample of Black male attempters, 41 percent were schizophrenic and 18 percent were bipolar.

It is important to recognize the supportive role of the extended family for Afro-Americans and the way in which interpersonal conflict can precipitate suicide attempts. Often, the relative who accompanies the suicide attempter has been involved in the events that preceded the attempt. The initiation of couple- or family-oriented crisis intervention in the ER can clarify the stressors and their meaning to attempters and their families and allow assessment of the family dynamics. The family's willingness to enter treatment often serves to influence the decision of the attempter to accept therapy and remain in treatment (Baker, 1984). The current crisis can be reduced and everyone in the system encouraged to use a walk-in center during a future crisis to talk through the problem. This intervention can help the family to recognize more easily when something is wrong in the future. Public health education activities taking place in churches and community centers would increase the awareness of the family members of psychiatric patients by helping them to understand the implications of changing behavior(s), thoughts, and mood(s) and would enable them to identify a decompensation in the patient. Also, such educational programs could enable a family to identify a Black adolescent or youth as severely stressed without the youngster attempting suicide to convey his or her distress. Such increased sensitivity by the collective family to the impending decompensation of a member will obviate the need for dysphoric adolescent females or psychotic young males to "act out" their increasing difficulty so as to bring it to the attention of the family (Rubenstein, Moses, & Lidz, 1957).

An 18-year-old single Black female resided with her mother and younger brother. Completing high school, she was anxious about obtaining employment, but unsure about her career direction. Her mother supported the family by working as a licensed practical nurse. The patient for several years had been responsible for meal preparation, household tasks, and the care of her younger brother. A maternal aunt visited frequently to "look in on" her sister's children. Facing graduation, the increased tension between herself and her little brother, and the breakup with her first boyfriend with whom she had been sexually active, she attempted an overdose by taking three 10-mg Valium tablets prescribed for her mother's back pain. After taking the pills, she called her aunt who took her to the ER.

Initially silent and withdrawn, she was reinterviewed with her aunt who presented a picture of a conscientious, reliable, and responsible young woman who had assumed the role of surrogate mother to her younger brother. The accidental death of her father, an innocent bystander to a street fight, had created financial insecurity for the family. Her mother worked swing shifts as well as overtime to maintain a firm economic base for the family. As her younger brother became a teenager, he began to resent the restrictions and test the limits of his sister's authority. Their mother, tired from frequently working two consecutive shifts, told her children not to argue. When the therapist suggested that it must be confusing to be both a parent and a child as well as to be facing leaving school, the patient became tearful and began to verbalize her ambivalent feelings toward her mother and brother and her anger at the loss of her boyfriend because "I always have to stay home and watch the kid."

Referred for family therapy, the children, mother, maternal aunt, and uncle-in-law were seen. The therapy focused on role definition, recognition of the different needs of all family members, and establishing mechanisms for family communication. The aunt and uncle were concerned and involved, providing both emotional and financial support. The aunt and uncle assumed the role of disciplinarian in place of the patient. The uncle established a schedule of biweekly outings with the teenage son and the family developed its own list of responsibilities for each member and the consequences of failure to implement the responsibilities.

Finally, the daughter and her mother were seen separately and their problems with communication were addressed. The daughter felt unappreciated and ignored. Her mother felt that her sacrifice was unappreciated, and she was concerned about the narrowness of her own life. The family established a plan so that the mother could take a long-delayed vacation and would have her evenings out. Mother and daughter clarified the ground rules and expectations concerning dating.

Alcohol Abuse and Alcohol Dependence

The use of alcohol by Afro-Americans has varied during their history in America. At the height of the Black temperance movement in the 1840s and 1850s, abstinence from alcohol was synonymous with freedom from slavery and moral uprightness. This resulted in increased respect and social opportunity (Baker, 1985). Slavery and demon rum were seen as examples of moral depravity. Chronic drunkenness was rare among Blacks at that time. The 1880 U.S. mortality statistics for deaths due to alcoholism or liver disease reported a rate per 1000 deaths from cirrhosis of "6.6 for Irish, 2.7 for Germans, 2.5 for whites, and 0.7 for coloreds" (U.S. Census Office, 1886, p. xvii). Following the Civil War, temperance was emphasized by Afro-Americans as a means by which one could attain economic and political equality and maintain social respectability. Only in the early 1900s when the temperance movement became associated with Black disenfranchisement and White supremacy did Afro-Americans withdraw from a movement that would reverse the gains established at emancipation (Herd, 1985).

The Black migration of the 1920s and 1930s, coupled with an economic recession and unemployment, involved more Black people in the production, sale, and consumption of alcohol. Increasing use of alcohol in the Black community was associated with the employment of Black entertainers in northern clubs ("speakeasies") and their involvement in the "night life." From this period on, alcohol progressively became a public health problem in the Black community (Herd, 1985).

Today, mortality statistics are alarming. Herd (1983) reported that seven cities (Baltimore, Chicago, Detroit, Los Angeles, New York, Philadelphia, and Washington, DC) accounted for 50 percent of *all* cirrhotic deaths occurring in Blacks. The cirrhosis mortality for Black males ages 25 to 34 was 10 times the cirrhosis mortality rate for White males of the same age. When all age groupings were reviewed, the mortality rate for Afro-Americans was twice that of Whites (Herd, 1983). Gary and Gary (1985) noted that, although Black women were more likely to be abstainers, when they did drink they were more likely to be heavy drinkers and to participate in a relatively high percentage of escape drinking. Further, the age-adjusted death rate per 100,000 for females with chronic liver disease and cirrhosis of the liver was 7.0 percent for White females and 14.4 percent for Black females (DHHS, 1983). Cirrhosis was identified as one of the six causes of the observed excess deaths in Blacks between 1979 and 1981 (Task Force on Black and Minority Health, 1985). In males and females up to age 45 cirrhosis was responsible for 4.9 percent of the excess deaths observed in Blacks compared to Whites. In males and females up to age 70 cirrhosis was responsible for 3.7 percent of the excess mortality. Clearly, cirrhotic deaths were a particular issue for Blacks below the age of 45.

Lelbach reported in 1975 that 15 to 25 years of heavy drinking was required for cirrhosis to emerge. Johnson (1975) noted that alcoholism in Afro-Americans was a disease of late adolescence and early adulthood. Bell, Thompson, and Lewis (1985) emphasized that a 35-year-old Black male being evaluated for hallucinations can have a drinking history of 20 to 22 years. Robin, Murphy, and Breckenridge (1984) showed that young Black men drink heavily and start at a younger age; one out of eight of their Black subjects reported having a drink before age 11. Further, Viamontes and Power (1974) reported earlier drinking among Blacks from a lower socioeconomic background in comparison to Whites. Primm and Wesley (1985) discussed the treatment of the multiply addicted Black alcoholic.

Although the studies are few, there are some data concerning Black female alcoholics. Miller, Lescault, and Heller (1980) reported on their sample of 405 females, of whom 31 percent were Black. In this sample, Black women were younger, had lower educational status, were more likely to be receiving welfare assistance, tended to be Protestant as opposed to Catholic, and were less likely to have an alcoholic nuclear family member than White women in the study. The reader is referred to the work of Gary and Gary (1985), which provides a comprehensive review of the current studies of Black female alcoholics.

The larger society's attitude toward the use of alcohol will require change. Currently, media present alcohol use as an enjoyable, sophisticated, and relaxing activity. The increasing activities of Mothers Against Drunk Driving (MADD) are presenting the negative consequences of alcohol use.

> A 32-year-old single Black male (W.S.) was brought to the emergency room of a general hospital by the police. He was tearful, distraught, and reported suicidal ideation. He also reported accusatory auditory hallucinations. Alcohol had been used prior to his ER arrival. He was referred for inpatient treatment of a schizoaffective episode, depressed.
>
> Physiologic evidence of a withdrawal was identified, after which a careful substance abuse history was obtained. The patient, W.S., began drinking at age 13 "to be like Dad." Within a year he was drinking over 2 pints of alcohol daily, had dropped out of school, and was of concern to his family. The death of his father ended all attempts by W.S. to control his drinking. A history of frequent arrests for disorderly conduct and frequent ER visits for treatment of alcohol-related injuries began. When he was age 23 his mother, brother, and other family members refused to attempt to help him anymore. He was ostracized. At age 31 he began a relationship with a 21-year-old single woman whom he met in a bar. His admission was precipitated by his celebration of the birth of his first child, a son.

Treatment began with a focus upon diagnosis. By history and from old medical records it was established that W.S. was dysphoric, distraught, and hallucinating whenever he used alcohol. In group and individual therapy he was confronted consistently about his alcoholism so as to break through his denial. Biologic and extended family members refused to participate in treatment because "we went through all of this 10 years ago . . . and he didn't change."

In individual therapy with a Black male therapist, issues of self-esteem and "proving oneself" were addressed. Maternal and paternal grandparents being deceased, his alcoholic father had been his only male role model. No extended family members lived near the family, and his mother was not involved in church. Trying to prove his manhood by "being able to drink with the guys," W.S. was unable to control his drinking.

Therapy focused upon his ability and need to take control of his life. When his feelings toward his son were explored, W.S. was adamant in wanting to be "a real father to my son," to be available, responsive, and supportive. Identifying that this was the relationship W.S. missed with his father, W.S. began a mourning process for the lost opportunity for such a relationship with his father, and the loss of 18 years of his life.

The treatment focus shifted to a definition by W.S. of the various roles involved in being a man: friend, husband, lover, father. Clarification of his lack of work skills, the lack of mastery in any role, and the lack of effective male role models was developed. Within the therapeutic alliance, the therapist moved from rejected distant father to a caring mentor, similar to a maternal uncle with whom W.S. was close until the uncle died of a heart attack (W.S. was 12). As W.S. began to feel strong enough to take a risk, he was referred to a rehabilitation day hospital program. He maintained sobriety with Antabuse and Alcoholics Anonymous for 9 months, and his girlfriend joined him in couples therapy and they began an exploration of their expectations in the relationship.

Misdiagnosis Versus Differential Diagnosis

Historically, Black persons who reported auditory or visual hallucinations and paranoid ideation were diagnosed more frequently as schizophrenic (Cannon & Locke, 1976). The disparity between the prevalence of schizophrenia and manic-depressive illness in England and that in the United States (Cooper et al., 1972) further stimulated a review of American diagnostic procedures. The past 10 years have seen the beginning examination of psychiatric diagnosis by American psychiatrists (Taylor, 1978).

The presence of affective illness in Black persons has been underdiagnosed because in the past Black persons were regarded as too jovial to be depressed or too impoverished to experience object losses (Prange & Vitols, 1962). Several authors (Adebimpe, 1981; Bell & Mehta, 1979; Jones et al., 1981) studied Black patients and summarized their patterns of presenting illness.

In a multihospital, collaborative study sponsored by the National Institute of Mental Health, Black and White patients were screened for the presence of depressive symptoms by two clinicians prior to entry into the study of the diagnosis of depressive illness. Thus clinical features of depression were similar for Black and White patients in the study. Although the authors controlled for age, sex, and social class, White patients were diagnosed more often as depressed and Black patients were diagnosed more often as having some form of schizophrenia. The authors of this study (Raskin, Crook, & Herman, 1975) found it difficult to explain these diagnostic differences. Adebimpe (1981) emphasized the importance of psychiatrists' knowledge of these findings. He argued that factors that could contribute to misdiagnosis were the social and cultural distance between patient and clinician, stereotyping of Black psychopathology, false-positive symptoms, biased diagnostic instruments, and the combined effects of various sources of diagnostic error.

Jones and colleagues (1981) demonstrated that psychotic symptoms in Black persons were not pathognomonic of paranoid schizophrenia. Further, the work of Bell and Jones and their colleagues questioned the frequently taught axiom that bipolar patients were college educated, middle-class, and usually White. Poor Black patients also manifested the symptoms of bipolar illness that responded to treatment with lithium carbonate and neuroleptics. Studies by Vitols, Waters, and Keeler (1963), Liss, Weiner, Robins, and Richardson (1973), Sletten, Schuff, Altman, Ulett (1972), and Singer (1977) demonstrated that hallucinations and delusions occurred more frequently among Black persons in the populations these authors studied. These findings led Adebimpe (1981) to caution against making the diagnosis of schizophrenia in Black patients based solely upon these symptoms, which also were seen in mania, psychotic depression, chronic alcoholism, and acute organic brain syndromes. Adebimpe cautioned that if hallucinations and delusions occurred more frequently in any group of patients there was a likelihood that schizophrenia could be overdiagnosed in that patient group. Two well-designed multicenter studies demonstrated the diagnostic disparity between Black and White patients with the same psychopathology. Simon, Fleiss, Garlans, Stiller, and Sharpe (1973) compared the diagnoses of psychiatric researchers who used a structured mental status interview with the diagnoses of the hospital psychiatrists in nine New York State mental hospitals. They found that race and diagnosis were associated strongly based on the hospital clinician's diagnosis, with Black patients diagnosed as being schizophrenic and White patients diagnosed as having affective illness.

The presence of psychotic symptoms in an Afro-American individual should stimulate a meticulous diagnostic effort. The differential diagnosis of psychosis (Slaby, 1981) should begin by obtaining all available historical data from past medical records, from immediate and extended family, and from the last place of residence (hospital, home, or halfway house). The individual may be unable to answer questions regarding past psychiatric symptoms, past hospitalizations, substance use, family history of medical and psychiatric illnesses, current medications, and toxic exposures due to occupation or environment.

The importance of ascertaining prior substance abuse is key to preventing a misdiagnosis of schizophrenia or affective illness. Further, the possibility of unsuspected drug exposure should be explored carefully for the etiology of psychotic symptoms in a previously well-functioning person who has no history of drug use. In Washington, DC, and Los Angeles, the use of phencyclidine (PCP) was endemic in the 1970s, and its use continues in the 1980s (Ayd, 1979; Fauman, 1976). Although the presentation varies based upon the amount of PCP ingested (Aronow & Dane, 1978; NIDA, 1979), certain behavioral patterns and physical findings are suggestive. An Afro-American college student was brought to an infirmary for evaluation by her cousin for irritability, tenseness, and a complaint of numbness in her extremities of several hours' duration. Nystagmus was evident. When asked to give her birth date, the patient was unable to recall the date, and, frustrated, she battered the office telephone to fragments. Subsequent history revealed that she had inhaled a marijuana cigarette 4 hours before her evaluation that unknown to her had been saturated with PCP. A urine test was positive for PCP.

The practice of "speedballing" (using a mixture of heroin and cocaine to produce a sustained euphoria and avoid the cocaine "crash") may produce a psychosis with dysphoria. An individual complaining of paranoid ideation and Lilliputian hallucinations (visual hallucinations of little people) whose psychosis resolves without intervention within 2 hours has manifested a cocaine psychosis (Goldfrank, 1981). A complaint of formications (a sensation of ants creeping upon the body—"cocaine bugs") may facilitate the diagnosis.

Cultural practices should be explored also. An African male convinced his Afro-American wife to ingest a mixture of juices that contained 2 tablespoons of nutmeg. The wife's symptoms of visual hallucinations, time distortion, depersonalization, and paresthesias subsided in 12 hours from the time of ingestion without psychopharmacologic intervention and only supportive monitoring (Faguet & Rowland, 1978). An inappropriate diagnosis of brief reactive psychosis was avoided by a detailed history.

Caffeinism due to excessive ingestion of caffein-containing beverages and the possibility of environmental occupational toxic exposure are other etiologies of psychotic symptoms to be explored. A stream contaminated by industrial waste may have fish contaminated with a large amount of an organometallic compound such as methyl mecury (Felton, 1972). The ongoing vigilance for alcoholic hallucinosis and alcoholic withdrawal delirium can prevent the misdiagnosis of these presentations. Finally, the manifestation of psychiatric symptoms due to medical illness such as thyroid disease (Davidoff, 1977) or endocrine disorder (Tonks, 1977) or due to medications, for example, steroids to treat sarcoidosis and systemic lupus erythematosis (SLE) in Black patients (Boston Collaborative Drug Surveillance Program, 1972), must be considered.

H.T. was a 35-year-old single Black male with a psychiatric history beginning at age 20. Diagnosed as a paranoid schizophrenic, he had been maintained on 25 mg of prolixin decanoate intramuscularly at 2-week intervals for 6 years. He had been stable and asymptomatic for 4 years. Within a 4-day period, he became increasingly agitated. Reporting auditory and visual hallucinations of God and the devil, H.T. began pacing and sleeping less than 2 hours in a 24-hour period. He was evaluated in an emergency room, and a diagnosis of acute decompensation in a chronic schizophrenic state was made. He was referred for inpatient treatment, and his mother and sister were interviewed. Two recent stressors were revealed: the return of a recently separated brother into the family household and the decision by an adopted brother to drop out of a local community college. H.T continued to have a hostile relationship with his separated alcoholic brother, who denigrated H.T. when drinking. The family reported that H.T. episodically drank one or two cans of beer per week. With the return of his separated brother, he drank no alcohol. H.T. had had a very close and loving relationship with his adopted brother, who H.T. believed no longer visited him due to the return of the separated brother.

A review of his prior 13 hospitalizations revealed a pattern of psychotic episodes at 8- to 12-month intervals with a similar clinical presentation without a specific psychosocial stressor in many of the admissions. The fourth hospitalization at age 23 was precipitated by the loss of his girlfriend, who had drowned during a family outing that H.T. did not attend. The admission note reported that he was depressed in mood, tearful, psychomotorically retarded for 2 months before admission with positive neurovegetative signs. Auditory hallucinations began a week before admission. Other admission notes reported flight of ideas, pressured speech,

> psychomotor agitation, and a driven quality to both speech and behavior. In view of the data the diagnosis was changed to bipolar disorder, manic.
>
> As H.T. gradually stabilized on lithium carbonate and neuroleptics over a 6-week period, he revealed his fear that his brother, the devil in his hallucinations, would assault him again with a knife. This assault had triggered his eleventh admission. The revelation of this family secret resulted in fuller discussion of the family history. H.T.'s father, an episodic drinker, had battered his wife on occasion in front of the children. This infrequent behavior had ceased before H.T. was age 14. He reported his fear that his mother would be seriously injured and die. At this point in therapy, H.T. was unable to articulate his feelings toward his father.
>
> As H.T. improved, his adopted brother began to visit him on the unit. A family meeting was held involving them both. In this meeting, they reaffirmed their affection for each other and the adopted brother was encouraged to explain his "rejection" of H.T.
>
> In a low-intervention medication maintenance program for several years, significant institutional intervention was required to enter H.T. in a group psychotherapy treatment for patients with bipolar disorder. Stabilized on lithium with household tensions significantly decreased at discharge, H.T. looked forward to continued work with his group and to beginning a job training program within 4 months.

TREATMENT

Psychotherapy

Since the Black population is a heterogeneous group, it is too complex a task to delineate specific treatment interventions here. Nevertheless, certain general constructs merit consideration. Economic resources as well as the Black patient's knowledge and appreciation of psychiatric resources will determine the patient's initial entry into treatment. An Afro-American professional may contact a physician of his or her acquaintance and request a referral. An Afro-American construction worker may walk into the local community mental health center for confirmation that the problem requires psychiatric intervention. In addition to the usual anticipatory anxiety of any new patient, the Afro-American seeking health care often cautiously wonders about the type of reactions that will come from the therapist. As noted by Adams (1950), Bell and colleagues (1983), and Spurlock (1982), the Afro-American patient brings to the initial session a well-honed ability to "read" verbal and nonverbal behavior. The Black patient will be likely to pick up any evidence that emanates from the therapist of anxiety, discomfort, or rejection. Once he has identified a hostile and nonsupportive environment, the patient will probably leave and not return to treatment.

If the treatment focuses on developmental tasks and the reworking of maladaptive patterns, individual psychotherapy is probably indicated. Following the initial evaluation of two or three sessions, it is important that the therapist review his or her findings in understandable language with the patient and discuss the prescribed treatment and its length. For some patients with a specific precipitant to an adjustment disorder, a focused, brief treatment contract may be the most efficacious therapeutic intervention. Upon completion of the brief treatment with resolution of the precipitating difficulties, the Black patient may be willing to address other areas of conflict that have been identified, such as maladaptive coping mechanisms, in a longer period of individual psychotherapeutic treatment. Once a successful therapeutic alliance and attained therapeutic benefit have been further established, work will then be feasible.

When psychotic illness or affective illness is involved, the extended family should be involved in the initial evaluation and at a relevant stage of treatment. Although significant tensions may exist between the patient and a family member or close friend, the therapist with family and group psychotherapy training and experience can use therapeutic skills to get the issues out on the table, gather a firsthand assessment of the Black patient's significant connections, and inform everyone about the current understanding of the illness, its course and treatment, and the expected outcome. Although all members of the extended family may not prove to be therapeutic allies, it will be helpful to know that a period of respite for the patient at the home of a specific relative is quite feasible, whereas time spent with another given family member has the potential of precipitating a relapse.

For Afro-American patients with extended family and significant others, taking the time to inform them of the treatment process and encourage their involvement is essential. Although medical treatment facilities are no longer segregated on the basis of color, the explanation to family members of mental illness, its course, treatment, and prognosis is frequently not emphasized enough. This time invested by the therapist is preventive medicine at its best, as informed family can monitor signs of progress as well as evidence of decompensation and bring the patient in before a frank psychotic deterioration or a full-fledged drug reaction has occurred. Education of the Afro-American patient and his or her extended family should be part of the process of forming the therapeutic alliance. Although this will vary for each specific patient, it should be a basic general strategy for the therapist.

The negative associations and daily insults Black Americans address (Pierce, 1970) provide a continued assault upon their sense of self-worth and their self-esteem. For some patients, the association of assertiveness training in a group with individuals and/or couples or family therapy can be beneficial. As specific assertive techniques are learned, they can be implemented in situations in which the Black patient has been silent, withdrawn, or inarticulate though angry. Developing an effective mechanism for verbalizing the feelings identified in the psychotherapeutic process in a manner that conveys his or her specific concerns results in a new sense of mastery that can be incorporated into the therapy. Dual modalities of treatment should be considered, where indicated, to facilitate the maximum improvement of the patient. The use of group assertiveness training may be of specific benefit to the young Black female suicide attempter whose self-esteem and image as a woman are dependent upon a relationship. If the relationship fails, then her sense of self is fragmented.

There have been to date no large-scale outcome studies of individual therapy, group therapy, family therapy, assertiveness training, and outpatient detoxification programs in Afro-American populations. As no Black population has the same heritage, social support networks, education, and socioeconomic status, it is inappropriate for any therapist to assert there is a "best treatment" that is applicable to all Black patients. The decision for a specific therapeutic regimen should be dependent upon the assessment, the diagnosis, and the wishes of the particular patient and his or her family.

Although the extended family and its support network as well as the Black church are important resources for Afro-American patients, these resources do not exist in all communities. For patients without these resources the therapist must include within the therapeutic prescription referral to a rehabilitation program as well as a local church group or community program for recovering patients to facilitate the rebuilding of a support network.

Drug Therapy

Unfortunately, no controlled clinical trials or prospective studies have been done to address the pharmacodynamics of the major classes of psychoactive medications (antipsychotics, antidepressants, and antianxiety) in Afro-American populations. Although anecdotal information and case reports are available, these have yet to develop into the indicated studies.

Shader (1982) emphasized three examples of known pharmacologic reactions that are relevant for Black populations. First, the ability to metabolize a given medication may require an acetylation step. Different groups are rapid or slow acetylators. Approximately 45 to 55 percent of Afro-Americans are slow acetylators and more at risk to drug-induced systemic lupus erythematosis upon exposure to marker drugs. Phenelzine, a monoamine oxidase inhibitor used in the treatment of depression, is one such medication.

Second, Shader (1982) pointed out that part of the differential diagnosis of pain in an Afro-American includes sickle-cell crisis. As a sedative, hypnotic medication could decrease respiration, increase hypoxia, and worsen the crisis. The emergency room physician must be alert to this possibility before prescribing. Also, if a bipolar patient had sickle-cell anemia, it is theoretically possible that the two diseases could have an additive effect upon the kidney. Sickle cells alter the current in the medulla of the kidney and affect the reabsorption and retention of reabsorbed water. Lithium in such a patient would affect the reabsorption of water in the distal tubule, further compounding the problem of reabsorbed water.

Third, there is research evidence in animals that exposure to lead when the animal is immature, with subsequent absorption of lithium as an adult, tends to cause irreversible central nervous system disease (Mailman et al., 1978). As poor Afro-Americans have a greater exposure to lead-based paint during childhood because of restricted housing options, there may be an increased risk for such Black patients on lithium who have a history of elevated lead levels. Obviously, further research is needed.

In the emergency room setting where a hallucinating Black male patient may be feared by the staff who is expecting him to become violent and assaultive, too often "knocking him out" or putting him in a "Haldol straitjacket" becomes a reflex response. Although the sedation of a psychotically disorganized patient is highly effective (Simpson & May, 1985), the dose estimated to achieve sedation in a Black patient may be very different from that required to sedate a White patient. A retrospective review of emergency room and inpatient records comparing age, sex, diagnosis, symptoms, and weight-matched samples of Black and White patients may provide an interesting contrast in the psychopharmacologic management of the same diagnosis and comparable symptomatology in two racial groups.

In treating the Afro-American inpatient, it is important to remember that titration of a dose of medication requires 4 to 5 half-lives of the prescribed dose to reach a steady state (Mayer, Melmon, & Gilman, 1980). Therefore, the steady-state serum levels will lag behind the actual dose being administered. Finally, the Black patient who appears to be refractory to high-dose neuroleptics may reflect the fact that one has achieved a "toxic" serum level of antipsychotic medication. *Dose reduction* and environmental management over a period of 5 to 7 days can effect the clinical improvement that increasing the dose of antipsychotic medication has not.

Special Population Considerations

Psychiatric disorders occur throughout the life cycle in the young, the middle-aged, and the elderly. The onset of many psychiatric disorders occurs in the teenage years and the twenties. While adolescents and young adults are frequently involved in suicidal behavior, homicide, and sexual assaults, the mental disorders of affective illness (unipolar and bipolar), adjustment disorders, and some variants of schizophrenia occur from youth through ages 30 to 50. Substance abuse, particularly alcohol, remains a concern throughout the Afro-American life cycle (Baker, 1985). In older cohorts (age 60 and over) disorders of cognitive impairment have been recently a major research focus (Folstein, Anthony, Parhad, Duffy, & Gruenberg, 1985; Mortimer, Schuman, & French, 1981).

There has been little focus upon the psychiatric illnesses of older Afro-Americans (Baker, 1982, 1987). Specific data about the Black elderly are sparse. Two previous studies have included data on the Black elderly. Folstein and colleagues (1985) reported on an elderly eastern Baltimore sample that was part of the Epidemiologic Catchment Area survey. Although the numbers were small, the Black participants showed a trend to an increased incidence of multi-infarct dementia. Schoenberg, Anderson, and Harer (1985) completed a prevalence study of dementia in rural Copiah County, Mississippi, and in this sample, which was 39 percent Black, the prevalence of severe dementia was higher in Blacks than in Whites. With the early onset of drinking and heavier drinking at a younger age in Black Americans (Robins et al., 1968), the prevalence of cognitive impairment due to alcohol (alcoholic dementia) may be higher in Afro-Americans (Baker, 1987). Research into mental health problems in older Black Americans as well as specific studies of dementia is needed. As both multifarct dementia and alcoholic dementia are preventable, irreversible diseases through regulation of hypertension and abstinence from alcohol, the public health implications of these initial studies are of clear importance in public health planning as well as in the implementation of a research strategy for Black Americans (Baker, 1987). Although the 1981 White House Conference on Aging emphasized the importance of implementing studies in minority elderly populations (White House Conference on Aging Report, 1981), definitive studies have not been published to date. Other studies of mental disorders in non-Black or mixed populations suggest that 25 to 35 percent of persons over age 65 are depressed (Weissman & Myers, 1979), have adjustment disorder (Straker, 1982), and exhibit paranoid disorders (Post, 1980). Comparable data in Black populations do not exist. The Epidemiologic Catchment Areas Survey (Rieger, Myers, Kramer, Robins, & Blazer, 1985) was designed to provide both prevalence and incidence data on mental disorders in probability samples at five sites. In both the eastern Baltimore site and the Durham, North Carolina, site, there was a significant population of Afro-Americans. As the data are analyzed, perhaps additional information about the Black elderly participants will provide some of the missing information. The National Black Survey completed by Jackson's group in Detroit may provide important data on the perception by Black people of their circumstances and their physical and mental health (Jackson, Chatters, & Neighbors, 1982). Research into mental health problems in older Black Americans as well as specific studies of dementia is needed (National Institute on Aging, 1987).

SUMMARY

This chapter has focused upon the psychiatric disorders in Afro-Americans and their treatment. A historical context has been provided to clarify the past history of psychiatric diagnosis and treatment for Black Americans and the problems in diagnosis that resulted from conscious and unconscious biases in clinicians and researchers. Factors facilitating and negating the formation of therapeutic alliance were discussed. Case histories were presented to illustrate diagnostic issues and treatment strategies. Areas of future research including clinical trials of therapeutic blood levels as well as psychiatric illness in older persons were presented. The importance of an empathic, sensitive, and culturally informed therapist was emphasized as the effective psychotherapist for Black Americans, exclusive of racial or cultural background.

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Journal of Applied Rehabilitation Counseling

The Interaction Between Disability Status and the African American Experience: Implications for Rehabilitation Counseling

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This article provides information that is useful to rehabilitation counselors and human service professionals providing services to African Americans with disabilities. The potential double bias of being African American and disabled is examined in the article. Special focus is on the similarities in stigmas experienced by persons with disabilities and members of the African American community and how the interaction between minority race status and disability status effects the delivery of rehabilitation services to African Americans. The client-centered approach is described and suggested as a theoretical orientation to be adopted by rehabilitation counselors to lessen the impact of a double stigma on this population.

Counseling ethnic minorities with disabilities is a topic deserving scholarly debate and discussion in the counseling literature. If quality counseling services are to be provided to ethnic minorities with disabilities, rehabilitation counselors and human service professionals must examine the issues involved in interacting with this client group. As suggested by Herbert and Cheatham (1988) and Kunce and Vales (1984), the success of rehabilitation counseling services to ethnic minorities is dependent upon the counselor's understanding of the life factors unique to clients whose sociocultural experiences are different. For example, the rehabilitation challenges facing African Americans with disabilities are varied and complex and require counseling approaches that are sensitive to the idiosyncracies of the African American community. African Americans comprise about 12% (30 million) of the total United States population and are the largest racial minority group in the nation. Though African Americans have made remarkable strides in many spheres of life in the past few decades, discrepancies still exist in many other areas. Atkinson, Morten, and Sue (1989) reported that African Americans as a group still suffer the most severe underemployment, unemployment, undereducation, and miseducation compared to any other group.

The impact of economic and educational disparities on the African American community is particularly felt by its members with disabilities. According to Rogers (1987), there are nearly 22 million adults with disabilities in the United States. Walker (1988) noted that the 1980 census reported that 14.1% (approximately 2,280,000) of working age African Americans had one or more disabilities. On the other hand, 8% of Caucasian Americans had disabilities. According to Bowe (1983), an African American with a disability is more likely to be female (53.9% are female), to be 42 years of age, to have less than a high school education, and to be unemployed. Only 16.4% of African Americans with disabilities were employed in 1980, and they earned less than $3,000 a year on the average. The general unemployment rate of individuals with disabilities in the total population is 33% (Frieden, 1988).

The statistics cited above would suggest that being African American and disabled increases one's chances for economic poverty. Also, individuals who are African American and disabled cope with stigmas specific to both statuses (Atkins, 1986; Wright, 1998). Therefore, African Americans with disabilities pose a unique challenge for rehabilitation professionals. Sampson, McMahon, and Burkhead (1985) defined the primary function of rehabilitation as assisting individuals with disabilities to achieve their highest level of functioning in order to facilitate entry or re-entry into the workforce. Such a definition is based on the assumption that vocational placement will generate a domino effect that will have a positive influence on the other aspects of an individual's life. For instance, being employed enables one to care for oneself and one's family. Self-sufficiency is a great self-esteem booster, and a healthy self-esteem is one precondition for healthy relations with others. Healthy relations with others can contribute to one's general satisfaction with life.

There is a need in the counseling literature to address the issues relevant to the rehabilitation of African Americans with disabilities. Wright (1988) and Atkins (1986) indicated that human service professionals need to be cognizant of the cultural issues involved in serving African Americans with disabilities. The purposes of this article are to examine the similarities in stigmas between the statuses of African American and disability; to explore the interaction effects of minority race status and disability on the delivery of rehabilitation services to African Americans; and to propose the client-centered approach for lessening the combined effects of a double stigma on this population.

Relationship Between Disability and Minority Status

The similarities in stigmas and inequities experienced by African Americans and persons with disabilities are numerous. Historically, both groups have been excluded from the mainstream of American life and share an underprivileged status. Walker (1988) gave a brief historical account of societal perceptions of people with disabilities. Though some societies looked upon individuals with disabilities with "awe and reverence", in most societies disability has traditionally been associated with tremendous negativism. In the most recent past, as indicated by Walker, persons with disabilities have been "tolerated but not allowed to participate fully in society" and have been "consistently relegated ... to economic deprivation and dependency" (p. 184). It is safe to say that the stigmas associated with the African American minority status reflect these experiences. As noted by Wright (1983), racial minority-group members have always dealt with non-minority individuals who insist that they "not only know their place but also to keep their place--that is, to feel and act less fortunate than others." Wright (1983) suggested that the oppression of minorities stems from an ethnocentric attitude by non-minorities toward out-group members in general. Intrinsic to this attitude is the belief that one's race, culture, or nation is superior to all others. Wright (1983) developed a similar concept called "requirement of mourning" to describe the oppression of persons with disabilities. This concept explains the need of nondisabled individuals to preserve their values and elevate their own status by either (1) insisting to themselves that the person with the disability is suffering, or (2) devaluing the person for not suffering in the face of his or her misfortune. This process protects the nondisabled person's beliefs about self and enables them to rationalize the harsh realities of disability. When the person with the disability appears neither to suffer nor to comply with a devalued status, the nondisabled person often is disconcerted and shocked because their sense of safety is threatened. In comparison, Wright (1983) stated "Aren't some people disconcerted and even shocked when ethnic and religious minority-group members advocate equality or show in other ways that they deserve as much respect and opportunity for development as anyone else?"

In the area of education, Walker (1988) asserted that students with disabilities, similar to African American students, are less likely to receive encouragement and recognition for their efforts and to be recommended for participation in enrichment programs. Obviously, both persons with handicapping conditions and persons of African descent share a history of disempowerment which has stood in the way of them achieving their optimal potential. As Wright (1983) pointed out, both groups are not expected to perform well at school, and as a result suffer exclusion from opportunities for self-development solely as a function of their membership in the respective groups and regardless of their true capabilities. Funk (1987) asserted that the relegation of persons with disabilities to "inferior economic and social status" is viewed by most people as a direct and inevitable result of their physical or mental deficits. Likewise, there have been suggestions that the lower educational performance of the average African American is due to the inherently poorer intellectual endowment of the African American as compared to other ethnic groups (Jensen, 1969).

Herbert and Cheatham (1988) noted that either having a disability or being a minority can present stigmas that pose barriers to full participation in education, employment, and social opportunities. As asserted by Wright (1983), an individual is appraised according to the presumed characteristics of the group in which he or she is placed. For example, persons with disabilities are often stereotyped as having suffered a great misfortune and whose lives are consequently disturbed and damaged (Wright, 1983). Stereotypes also exist for minorities in the larger society. For example, African Americans are perceived as low achieving, promiscuous, and untrustworthy (Atkins, 1988). Wright (1983) asserted that the stigma associated with disability or minority status can be so intense and pervasive that it can overpower any other positive personal characteristics of the individual which may run counter to it. These observations by Herbert and Cheatham (1988), Wright (1983), and Atkins (1988) are significant because they suggest that African Americans with disabilities must learn to cope with what Marshall (1987) called the "double whammy"--racial discrimination and physical impairment. The double bias of being a member of both status groups can manifest itself through extreme prejudice on the part of nondisabled, non-minority individuals who lack awareness and sensitivity to the potential combined effect of being a minority and havimg a disability.

Implications for Rehabilitation Service Delivery

Herbert and Cheatham (1988) conducted a review of research pertaining to rehabilitation service delivery to African Americans with disabilities. Their review revealed that African Americans were less likely to be accepted for services compared to Caucasian Americans. If accepted, their cases were more likely to be closed without job placement, and if job placement occurred, then they received lower weekly incomes. Walker et al. (1986) conducted a study involving eight state and nineteen private rehabilitation agencies around the United States. They found that though there was a larger number of African Americans with disabilities, the percentage of Caucasian Americans receiving services was twice and sometimes three times that of African Americans.

There are numerous reasons why African Americans are underserved and fare worst in rehabilitation. Brewington, Daren, Arella, and Randell (1990) described three classes of obstacles to successful vocational rehabilitation. These were the client, nature of the rehabilitation program, and finally, society. Client variables may include temperament (motivation), interests, work experience, educational level attained, skills possessed, and so forth. Program factors include availability of resources (both manpower and monetary) and quality of staff. Finally, societal factors include attitudes prevalent in society that w[illegible] affect the success or failure of service delivery. Granted, the interplay between these variables is an intricate one. As Atkins (1986) indicated, clients enter a rehabilitation process with a set of beliefs, attitudes, values, and goals, and they encounter rehabilitation counselors with their own set of beliefs, attitudes, values, and goals. Undeniably, the interaction between client and counselor attributes could be critical in determining whether clients are accepted into a rehabilitation program and whether they leave the program "rehabilitated". As it is indicated in the preceding paragraph, the client's race appears to be a significant attribute.

Another important variable of rehabilitation service delivery is the client's previous life experiences. Being an American of African descent exposes one to a unique set of life experiences. It is these experiences which serve to shape one's view of the world. For instance, African Americans with disabilities are aware of stereotypes and negative attitudes held by the majority American society against African Americans in general. They know, for example, that the slow economic progress of African Americans is often attributed to laziness and low motivation to work hard (Atkins, 1988). This could stand in the way of African Americans with disabilities seeking out rehabilitation services. Even those that do seek out such services may do so with low success expectancy levels if their prior experiences with majority American institutions have been tainted by discrimination.

Rotter, Chance, and Phares (1972) postulated that previous experiences have a great influence on expectancy. Rotter (1954) had defined expectancy as "The probability held by an individual that a particular reinforcement will occur as a function of a specific behavior on his part in a particular situation" (p. 107). According to Weiner (1980), intensity and persistence of behavior are mediated by both expectancies of success and anticipated emotional responses to these outcomes. If these theoretical formulations are accurate, then as a result of prior experiences of exclusion, African Americans with disabilities are likely to enter a rehabilitation process with low expectancies for success. Therefore, African American clients with disabilities may not exert as much effort in working with rehabilitation counselors, especially if they sense an adherence to negative stereotypes.

Some of the other client variables that affect the rehabilitation process such as educational attainment, skills possessed, and work experience are to a large extent determined by the client's race. The statistics provided previously substantiate this claim. The "second generation discrimination" in the schools described by England et al, (1990) ensures that most African American children drop out before they have acquired any marketable skills. According to England et al, those who stay in school are often trapped in vocational classes that further ensure that they end up in menial and low income occupations. Therefore if disability occurs, it finds African Americans poorly prepared to compete in the world of work. Skill deficiencies resulting from life experiences prior to their need for rehabilitation services lessen their chances of benefitting from such services.

Client-Centered Approach

A rehabilitation counselor can neither alter experiences that have shaped the characteristics that a client brings into a rehabilitation situation nor convert society and cleanse it of attitudes that pose barriers to the full rehabilitation of African Americans with disabilities. However, a rehabilitation counselor may, by first adopting a client-centered approach to counseling, make a difference. The client-centered approach, developed by Carl Rogers, dictates that every human being deserves acceptance and unconditional positive regard--respect for the mere reason that one is human. Therefore, an adoption of this philosophy would be reflected in the rehabilitation counselor's understanding and acceptance of the African American client with a disability from the client's own perspective; understanding and accepting the client's background, culture, and personality even though these might be different from those of the counselor (Corsini, 1979; Herbert & Cheatham, 1989).

Adoption of the client-centered approach would also require rehabilitation counselors to engage in a careful introspection in order to examine their own biases, attitudes, and values for the purpose of self-awareness and personal growth (Corsini, 1979). This approach would encourage rehabilitation counselors to purge themselves of those attitudes and behaviors that might impede the overall optimum growth of their clients. Working with African Americans, in particular, requires that a rehabilitation counselor avoid being driven by derogatory stereotypes in dealing with clients, and not only to appreciate the strengths these clients bring into the situation but also to build on them.

Carl Rogers espoused the importance of recognizing the client's positive attributes when using client-centered counseling (Corsini, 1974). The significance of building on the assets and positive elements (e.g., desire to be self-reliant, desire to be in control of one's own destiny, etc.) of African Americans was emphasized by scholars on the rehabilitation of African Americans (Atkins, 1986; Atkins, 1988; & Cheatham, 1990). Respect for and valuing of the African American client's positive elements can be reflected in the rehabilitation counselor's willingness to involve the client as much as possible in examining possibilities and setting rehabilitation goals (Atkins, 1986). Obviously, if clients are allowed to participate in decision making, they will more likely commit to goals and take responsibility for the choices they make.

Sensitivity to the basic (immediate) needs of the individual is also paramount in the client-centered approach. It was indicated in an earlier discussion that despite an increase in the number of African Americans who have achieved middle class socioeconomic status, a large number is still trapped in poverty. Therefore, if immediate problems such as not having transportation or enough resources to live from day to day are not addressed first, long term positive outcomes of rehabilitation may not materialize. As Atkins (1986) noted, another function of rehabilitation should be advocacy - linking the clients with available resources or, better still, teaching them self-advocacy skills.

Conclusion

According to Kirchner (1987), the functions of rehabilitation include personal adjustment counseling, vocational counseling, job training, and assistance with job placement. Fulfillment of these functions depends partly on client variables such as race, work history, and educational level. However, counselor variables such as cultural biases and prejudices are equally important in influencing rehabilitation outcome. Despite client conditions such as those cited that make it harder for rehabilitation to fulfill these functions, genuine commitment on the part of rehabilitation counselors to make a meaningful difference in the lives of their clients, regardless of race, would go a long way toward offsetting the effects of these conditions. As the information in this article indicates, African Americans with disabilities are a complex client population with unique conditions that warrant special attention. Lack of awareness of the issues confronting African Americans with disabilities can result in rehabilitation case management problems.

Rehabilitation counselor education programs need to equip their trainees with minority-oriented counseling strategies. This does hot mean that there is a "cookbook" method for working with African Americans or other minorities. However, as Wright (1988) aptly put it, each minority group has experiences that bring forth a unique set of problems. It is imperative that rehabilitation counselors understand the collective experiences of the minority group members they are working with while at the same time being sensitive to the needs of individual clients. Preservice rehabilitation counselors need opportunities to work with minority clients. Workshops and seminars should be organized for both preservice and practicing rehabilitation counselors (Crystal & Alston, in press; Atkins, 1988). Seminars present a forum through which rehabilitation counselors can develop the necessary sensitivity needed to serve African Americans with disabilities. Also, workshops foster an atmosphere in which rehabilitation counselors can be challenged to confront their own attitudes and seriously reflect on how these might impact service delivery to African Americans and other minorities with disabilities.

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Problems in Diagnosing Schizophrenia and Affective Disorders Among Blacks

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In this country schizophrenia has been consistently overdiagnosed and affective disorders underdiagnosed, particularly among blacks and lower socioeconomic groups. The general causes of such misdiagnoses include overreliance on the classic thought disorder symptoms as pathognomonic of schizophrenia and, for affective disorders, lack of clearly defined boundaries between normal and abnormal mood and failure to realize that patients with affective illness can manifest cognitive symptoms. In addition to the above factors, misdiagnosis among blacks results from such factors as cultural differences in language and mannerisms, difficulties in relating between black patients and white therapists, and the myth that blacks rarely suffer from affective disorders. Clinicians and researchers must pay more attention to the effects of cultural differences on diagnosis, and baseline behaviors and symptomatology for blacks must be established.

Over the years major efforts have been made to address some of the problem areas in psychiatric diagnosis. *DSM-III*, the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (1), has been a significant development in psychiatry partly because it provides standard diagnostic criteria that have been tested for reliability and are operationally defined. In general, however, little attention has been given to diagnostic issues as they relate to blacks.

Several studies have shown that earlier diagnostic methods resulted in a consistent overdiagnosis of schizophrenia and an underdiagnosis of affective disorders (2–4). Blacks and lower socioeconomic groups have been particularly affected.

In other fields of medicine, diagnosis is arrived at by determining the etiological agent or malfunction involved in the illness and weighing it in conjunction with the accompanying symptoms. In psychiatry the etiological agents and malfunctions are generally unknown, and psychiatry lacks measurements, tests, and methods to establish their presence. Hence diagnosis has relied almost entirely on signs, symptoms, and behaviors—a major drawback because different illnesses may have the same or similar signs, symptoms.

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and behaviors. In addition, symptoms and behaviors may be culturally related and thus differ from one ethnic group to another.

The problems involved in psychiatric diagnosis have been particularly evident for schizophrenia and major affective disorders. Our review of the literature indicates that the misinterpretation and misunderstanding of three areas involved in symptom presentation have contributed to problems in the diagnosis of these conditions in blacks. These areas are disorder of thought content (hallucinations and delusions); disorder of thought process (looseness of association, incomplete thoughts, and flight of ideas); and the cultural distance between patient and therapist (as in language, behavioral mannerisms, and style of relating) when it hinders patient-therapist rapport.

This paper will review general problems in diagnosing schizophrenia and major affective disorders and specific problems related to the diagnosis of these conditions in blacks. Because it is impossible to address these two broad spectrums of disorder with any completeness in one article, we can present only an overview.

Schizophrenia: general diagnostic problems

Three major problem areas will be discussed, two of them reflecting current trends in the field.

The role of classic symptoms. The past emphasis on classic schizophrenic symptoms such as hallucinations and delusions as diagnostic criteria has contributed to the use of "schizophrenia" as an overinclusive label. The present decrease in emphasis on such symptoms is narrowing the diagnosis. There is an increased reliance on mood and other affective symptoms as more diagnostically useful, and a shift toward classifying schizophrenia as more similar to affective disorders in that affective disorders may include thought disorder. There is no longer a clear demarcation between symptomatology of schizophrenia and affective disorders (5). The use of classic symptoms has also given way to increased use of explicitly defined operational criteria, as in *DSM-III*, derived with an emphasis on reliability.

Schizophrenia has long been considered a disorder of thinking, and thus any symptom indicative of thought disorder, such as hallucinations, delusions, and looseness of association, has been considered pathognomonic for the illness. This view has also contributed to the overdiagnosing of schizophrenia.

Research in schizophrenia diagnosis has supported a symptom cluster approach over a pathognomonic approach (6). The past, almost relentless search for classic pathognomonic symptoms has proven futile. While Bleuler's four A's (7)—loosened associations, flattened affect, ambivalence, and autism—and Schneider's first-rank symptoms (8) have aided diagnosis, they have not assured accuracy. Pope and Lipinski (9) reported that several key symptoms of schizophrenia, such as delusions and hallucinations, are found in 20 to 50 percent of documented cases of manic-depressive illness.

Schizophrenia as a unitary disease. Walters (6), like many others, raised the issue of whether schizophrenia is a single disorder or a collection of separate but related disorders. Kinney and Jacobsen (10) indicated there may be several subtypes of schizophrenia based on etiology. One type may be associated with a strong family background of schizophrenia, a second type with perinatal cortical damage, and a third with social and environmental factors. The existence of the last subtype could have special significance for blacks and others in lower socioeconomic groups.

Others have noted that the manifestations of schizophrenia might be general symptoms of numerous illnesses, much as chills and fever are, rather than specific symptoms of a particular illness. This view also suggests that schizophrenia may be a host of different disorders. The concept that schizophrenia is a unitary disease is currently fading (5).

Overdiagnosis and misdiagnosis. Obviously, both the problems noted above affect overdiagnosis. Another problem that has led to the overdiagnosis of schizophrenia is misdiagnosis. The curse of being familiar or common is that a familiar entity, such as schizophrenia, inherits what is marginal or unclear. The tendency to diagnose unclear and confused clinical pictures as schizophrenia persists.

Some researchers, such as Pope and Lipinski (9), state that American psychiatry has indeed overdiagnosed schizophrenia and underdiagnosed manic-depressive illness. They report that the "classic" symptoms of schizophrenia are ineffective in differentiating between schizophrenia and manic-depressive illness. They feel the diagnostician must supplement the presenting symptoms with additional information, such as a family history and course of illness, before reaching a diagnosis.

Schizophrenia: specific problems for blacks

Studies have indicated that just as schizophrenia is overdiagnosed in the general population, it is overdiagnosed in blacks, and that in this country blacks are more likely to be overdiagnosed than whites (11–18). Being black and requiring psychiatric treatment carries a significant risk of being labeled schizophrenic.

Adebimpe and associates (14) reported that "the higher incidence of schizophrenia usually reported in blacks as compared to whites is not found when strict diagnostic criteria are used in making the diagnosis." They suggested that "clinicians overdiagnose this disease in blacks because they are unduly impressed by symptoms such as hallucinations and delusions which are characteristic but by no means pathognomonic of schizophrenic illness." They believe that some blacks experience a variety of nonschizophrenic hallucinations.

Mukherjee and colleagues (11)

compared the misdiagnosis of schizophrenia in bipolar patients who are black, Hispanic, and white. In their study black and Hispanic bipolar patients were "at a higher risk than whites for misdiagnosis as schizophrenic, particularly if they are young and experience auditory hallucinations during affective episodes."

Simon and others (16) compared research diagnoses with hospital diagnoses of black and white patients in nine New York State mental institutions. The hospital clinicians more often gave blacks the diagnosis of schizophrenia than of affective disorder; race and diagnosis were significantly related. However, the research psychiatrists' diagnoses were quite different, and race and diagnosis were not related. In a cross-cultural study of diagnosis in New York and London, Cooper and coworkers (19) reported similarly that blacks were overdiagnosed as schizophrenic and underdiagnosed for affective disorders.

Mukherjee and colleagues (11) noted further that "the misdiagnosis of bipolar patients as schizophrenic is also related to the lack of awareness that some delusions and hallucinations may commonly be seen in acutely ill patients. This is particularly important to bear in mind when evaluating black and Hispanic patients, since they may more frequently exhibit these symptoms during affective episodes [than white patients do]. Until these factors are better understood, the use of structured interviews, a clearer knowledge of phenomenology, strict adherence to operationally defined diagnostic criteria such as provided in *DSM-III*, and most importantly, explicit exclusion of manic or depressive syndromes before arriving at a diagnosis of schizophrenia should minimize misdiagnosis regardless of the ethnicity of the patient or the psychiatrist."

Some of the specific cultural problems affecting the diagnosis of schizophrenia in blacks include cultural differences between the black patient and white clinician, lack of understanding of the black norm, and stereotypic thinking.

Black patients' use of language, behavioral mannerisms, and style of relating, as well as the type of life experiences they have had, often are not understood by nonblack therapists. As a result such behaviors may be considered symptoms of psychopathology, most often schizophrenia. Language not understood is often considered evidence of thought disorder; styles of relating are sometimes misinterpreted as disturbance of affect; and unfamiliar mannerisms are considered bizarre. These mistakes are avoidable.

Haimo and Holzman (20) examined thought disorder in schizophrenics and normal controls. They stated that "the usual indications of schizophrenic thought disorder are not specific to a particular social class or race such as the white middle class, and therefore patterns of thought expressed in language used by lower-class blacks and whites are distinguishable from examples of thought disorder, although higher-social-class patients tend to manifest higher levels of thought disorder than do lower-social-class patients."

Grier and Cobbs (21), in their book *Black Rage*, wrote about the "black norm," a body of adaptive character traits developed by blacks in response to a particular environment. They stress that this complement of psychological devices is essential to life for black men in America. For instance, they submit, "It is necessary for a black man in America to develop a profound distrust of his white fellow citizens and of the nation. He must be on guard to protect himself against . . . hurt. . . . For his own survival, then, he must develop a cultural paranoia in which every white man is a potential enemy . . . and every social system is set against him." This normal (for blacks) protective wariness is often mistaken as paranoia, symptomatic of schizophrenia.

A compounding issue is the reluctance and hesitancy that some blacks have in relating to a white therapist, which is born out of dislike and hostility. Such reluctance is most often manifested by strict control over affective response and a resistance to establishing rapport and communication. These behaviors are often misinterpreted as flat or blunted affect and problems relating to others and may be mistaken as further evidence of schizophrenia. According to Grier and Cobbs, other character traits of the black norm are cultural depression, cultural masochism, and cultural antisocialism.

Stereotypic thinking that may affect the diagnosis are the views that schizophrenia is more common than other illnesses in lower socioeconomic groups, especially among blacks, and that schizophrenia more frequently occurs among blacks than among whites. These myths are self-perpetuating.

Affective disorders: general diagnostic problems

Although there are many general problems in the diagnosis of affective disorders, we shall address only two of the most fundamental concerns: the broad range of affective disorders and the mix of affective and thought-disorder symptomatology they can manifest.

Range of affective disorders. The lack of a clear demarcation between normal and abnormal mood creates special difficulties. Klerman (22) has pointed out that "because clinicians and investigators do not fully agree as to the complete range of affective disorders to be diagnosed as psychopathological, the boundary between normal mood and abnormal depressions remains undefined." The lack of clear demarcation also exists betwen normal mood and mania. At what point does more activity, more energy, greater functioning, and feeling good become abnormal?

A related concern is the number and type of illnesses that constitute affective disorders. Because mood illnesses are distributed across a wide spectrum from mild depression to life-threatening mania, it is often difficult to determine which disorder is present, particularly without knowledge of the patient's past history and previous course of illness. *DSM-III* groups all affective disorders together regardless of whether they have psychotic features or are associated with precipitating life events.

Symptomatology. Because affective disorders have always been defined as disorders of mood, the symptomatology has been considered to relate primarily to mood and activity, such as depression and psychomotor retardation or elation and hyperactivity. However, it is clear that affective conditions can incorporate symptoms of thought disorder.

Roukema and associates (23) found that 95 percent of their manic patients, as diagnosed by Research Diagnostic Criteria, clearly showed moderate to severe thought disorder that was characterized by bizarre idiosyncratic thinking. "Thus, if allowed to continue without treatment, the behavior, affect, and thinking of the manic state reach a combination that is difficult to distinguish from schizophrenia," they concluded. Delusions and hallucinations may also be part of the symptomatology of involutional, bipolar, and unipolar depression, all now termed major depression, whether single episode or recurrent.

Affective disorders: specific problems for blacks

As noted above, most earlier studies have found lower rates of affective disorders and higher rates of schizophrenia among blacks as compared with whites. These findings have always been controversial. The reports were often statistically biased and were based on stereotypes that blacks rarely suffered from depression or manic-depression (24–26) and that such disorders were upper- and middle-class illnesses (24,27,28).

More recent studies have demonstrated a higher incidence of major affective disorders among blacks than previously believed. For instance, Keisling (29) found no evidence that blacks had manic-depressive illness less frequently than whites. Dovenmuehle and associates (30) and Tonks and associates (31) have reported higher rates of manic-depressive illness among blacks and low-income groups than among whites and higher income groups. In addition, Tonks and associates and Warheit and others (32) found higher depression scores among women, blacks, young persons, and those in low socioeconomic groups.

In a study examining clinical symptoms of manic-depressive illness in black patients diagnosed as manic-depressive by *DSM-III* criteria, Jones and coworkers (33) found the clinical symptoms of manic-depression, manic type, to be similar to the clinical symptoms reported for white patients. They stated, "The precise expression of a particular symptom may assume any of a potential number of allomorphic forms with the exact selection possibly being influenced by a number of factors." They believed the variance in symptom presentation to be one of the factors contributing to misdiagnosis in general. In other words, the same symptoms may be expressed through a variety of behavioral actions that are determined by other factors, such as culture.

Further confirmation of the incidence of manic-depressive illness among blacks comes from the retrospective study by Jones and associates (34) of a random sample of lower income urban blacks; 15 percent were diagnosed as manic-depressive according to *DSM-III* criteria.

Thus it appears that misdiagnosis of affective disorders among blacks has been a primary problem. The causes arise both from the general problems of diagnosing affective disorders described above and from factors specifically affecting blacks, and thus the causes are closely intertwined.

For instance, the general lack of a clear demarcation between normal and abnormal mood may become more confusing if what is normal for blacks is not well understood. The erroneous beliefs that blacks are generally happy people who seldom suffer from depression makes the distinction between a normal state and depression less clear. Mild and even moderate depression is more likely to be considered in the realm of normal. Likewise, if manic-depression is believed to occur rarely in blacks, hyperactive behavior is more likely to be seen as normal.

The general issue of symptomatology in affective illness clearly affects blacks specifically. As stated, blacks and Hispanics with affective disorders may exhibit delusions and hallucinations more frequently than whites (11). Blacks are at higher risk of being misdiagnosed if thought disorder is not considered symptomatic of affective illness. In case studies demonstrating bipolar illness in a low-socioeconomic black population, Roukema and associates (23) found that diagnostic errors were made on the basis of symptoms resembling schizophrenia. Patients with these symptoms were not schizophrenic but in fact were in the later stages of the manic phase of manic-depressive illness.

Social and cultural differences between black patients and white clinicians are more of a problem in the diagnosis of schizophrenia, but they can also be operative in affective disorder. Language, mannerisms, and style of relating may be misinterpreted as depression or hypomania if the clinician is not familiar with the patient's culture and social customs. A black patient's unwillingness to relate to a white clinician may be seen as depression instead of resistance.

Adebimpe (13) comprehensively reviewed several possible causes of misdiagnosis of black patients: social and cultural distance between patient and clinician, stereotypes of black psychopathology, false-positive symptoms, biased diagnostic instruments, and the combined effects of various sources of diagnostic error. Each of these factors has also been cited in other reports.

Bell and Mehta (35) provided three case histories demonstrating the misdiagnosis of manic-depressive illness in blacks as the result of institutional dynamics and clinical error. In a second study they found a rate of manic-depressive illness among their black patients similar to rates reported in surveys of white patients (36). However, the black patients had been more frequently misdiagnosed than white patients and had received inappropriate treatment.

Conclusions

The state of the art in psychiatric diagnosis has enabled the field of psychiatry to determine the existence of hallucinations in schizophrenia and in major affective disorders, but there are no studies differentiating the nature of the hallucinations in the two illnesses. The inclusion in *DSM-III* of nonsymptom criteria, such as duration of symptoms and age of onset, in addition to symptom criteria may help resolve some of the problems incurred when diagnosis is based solely or primarily on symptoms. However, it is clear that more than *DSM-III* will be required to resolve these and other problems in diagnosis. The development of biological markers and other diagnostic methods will greatly assist the field of psychiatric diagnosis. However, all such diagnostic instruments, tests, and markers must be validated for use with blacks before they are employed.

Research to investigate more closely how the general diagnostic problems in psychiatry affect blacks is needed. More attention must be paid, both in research and in clinical settings, to cultural and racial differences of black patients as they may affect the diagnosis. Finally, baseline behaviors and symptomatology for blacks must be established.

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The Chinese perception of mental illness in the Canadian mosaic

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Abstract

The author examines Chinese philosophical and religious teachings, their effects on the Chinese perception of mental illness, and the help-seeking behaviours of mentally ill patients and their families within the Chinese community in Canada.

On October 8, 1971, in the House of Commons, Prime Minister Pierre Elliott Trudeau announced his Government's multiculturalism policy. He described it as follows: "A policy of multiculturalism within a bilingual framework commends itself to the government as the most suitable means of assuring the cultural freedom of Canadians. Such a policy should help to break down discriminatory attitudes and cultural jealousies. National unity, if it is to mean anything in the deeply personal sense, must be founded on confidence in one's own individual identity; out of this can grow respect for that of others and a willingness to share ideas, attitudes and assumptions (Trudeau, 1978, p. 45).

More than 4,000,000 immigrants have entered Canada since the end of the Second World War (Leacy, 1983, p. 8), and it is estimated that during the next 15 to 25 years, 150,000 immigrants will be admitted into Canada each year (Statistics Canada, 1980). We are now living in a multicultural society, among men and women with different skin colours and languages, different standards and traditions in dress, habits, diet, different religions and, more importantly for health care professionals, different health beliefs and practices. A sound knowledge of cultural values and practices is especially important for health care professionals who work with psychiatric patients, since a variety of mental health problems are largely related to cultural contact and sudden cultural changes which leave the individual confused and helpless (Leininger, 1978, p. 105).

Although Chinese people began to emigrate to Canada more than a century ago, their traditional philosophical and religious teachings continue to have a great impact on the values, attitudes, and behaviour of the average Chinese Canadian (Ontario Ministry of Culture and Recreation, 1974, p. 1). It is important to realize, however, that the Chinese, like all other ethnic groups, are by no means homogeneous. They differ significantly according to their duration of stay in Canada, their geographical origin, their social class, and even their political affiliations.

The second- or third-generation Chinese Canadians, who are fluent in English and well integrated into the major culture, do not usually pose special problems for the health professional. It is the individuals who have a language barrier and whose cultural values differ from the dominant Canadian culture who require special sensitivity.

Chinese philosophical and religious teachings

Confucianism, Taoism and Buddhism are the three major philosophical and religious teachings that have guided Chinese moral and ethical considerations for centuries.

Confucianism sets the rules and regulations for social interaction; therefore, it has traditionally been the most pervasive influence on Chinese behaviour. Confucian teachings on social interaction stress reciprocity and loyalty, benevolence and righteousness, self-respect, self-reliance, self-control, and face-saving. Reciprocity means that one treats others as one would like to be treated. Loyalty is unquestioning allegiance and total subordination to one's superior and elders. Reciprocity and loyalty lay the foundation of authoritarianism, filial piety and the closely-knit family structure of the Chinese (Yang, 1967, p. 269). Benevolence is an awareness of others; that is, one should treat others in a kindhearted manner. Righteousness is doing what is appropriate according to benevolence. In the building of one's character, one should always demonstrate self-respect and self-reliance by exerting restraint over one's emotions, and by avoiding extremes. Face-saving, keeping an honourable family name, is a behavioural duty expected by both the family and the community, and the only way to accomplish it is by following Confucian teachings closely.

Taoism advocates non-action, detachment from the world, and a harmoniou personal life in relation to cosmological natural and social environments (Lin, K.M 1981, p. 95). Taoist views of nature em phasize cyclical changes; e.g. the cycle o birth and death, and belief in reincarnatio and spirits.

Buddhism, which originated in India stresses the temporariness and emptines of life. Reincarnation and the cause an effect of one's deeds are central belief therefore, it is very important to accumu late good deeds in order to reach a highe state of being in one's next life (Cher Louie, 1983, p. 200).

There is a lot of overlapping in the three major philosophical teachings, an most Chinese are not able to articulate th concepts involved. These teachings a internalized during the process of their u bringing.

Chinese perception of mental illness

The Chinese view of the etiology mental illness is largely influenced by Cl nese philosophical teachings and physic health beliefs. The multifaceted percepti of mental illness includes moral, religio physiological, psychosocial and gene factors.

- ***Moral factors***

Rules set by Confucian teachings regarded as the proper way of conducti one's life; therefore, any misconduct deviation from socially prescribed beh iour, especially in neglecting the resp due to ancestors, can result in mental ill for the person responsible or his desc

dants (Lin, K.M., 1981, p. 95). Usually, the male head of the family will draw upon Confucian teaching concerning the virtue of good conduct in the hope of correcting the mentally ill person's "misbehaviour."

- ***Religious factors***

Mental illness is traditionally believed to be caused by the wrath of gods and ancestors, incurred by the patient or his family members, in either present or former lives. For the Buddhist, prayers and offerings will be given at temples in the hope that good deeds will be accumulated to please the gods. As for the Taoist, priests will be hired to engage in magical healing through expulsion of evil spirits which are believed to have possessed the patient (Lin, T.Y. and Lin, M.C., 1981, p. 387).

- ***Physiological factors***

Due to their philosophical teachings, it is very difficult for Chinese to express their emotions and feelings. Studies (Tseng, 1975; Leong, 1976; Kleinman, et al., 1978) have shown that the practice of somaticizing emotional feelings is prevalent among Chinese Canadians today. The physiological explanation of health and illness rooted in the Yin-Yang theory was first defined in the "Yellow Emperor's Classic of Internal Medicine" more than 5,000 years ago (Spector, 1979, p. 214). Yin represents the female principle, the negative energy that produces darkness, cold and emptiness. Yang is male, the positive energy that produces light, warmth and fullness. Yin-Yang exert power not only over the universe but also on human beings; therefore, all illness is caused by an imbalance of nature's two opposing forces. According to the Yellow Emperor's Classic of Internal Medicine, a person is rendered mentally ill or more susceptible to mental illness by five harmful emanations of Yin-Yang (Veith, 1967). The five disturbances are numbness, wildness, insanity, disturbance of speech, and anger. Excess or deficiency of physiological functions, such as breathing, eating, bowel movement, sexual activities, and physical exhaustion are the causes of the disturbances. With the influence from Western medicine, hormonal imbalance, vitamin deficiency and brain dysfunction have become the modern additions to the somatic orientation of the Chinese to mental illness (Lin, T.Y. and Lin, M.C., 1981, p. 387). Consequently, one will often hear the mentally ill patient complain of malaise and lack of vitality caused by his weak kidneys, rather than about feeling depressed. In order to replenish vitality and restore the balance of Yin-Yang forces, remedies are sought by the family, usually in consultation with traditional herbal doctors and respected elders in the kinship; acupuncture is also a popular alternative treatment for the patient (Spector, 1979, p. 219). Such physical treatments often render psychological relief to the family for their shame or guilt over the patient's mental illness, which they believe may have been caused by their misconduct.

- ***Psychological factors***

Crisis situations, extreme psychosocial stress such as breakdown of family relationships, failure in career and finance, death and mourning of a loved one, are all viewed as potential causes of mental illness. However, the Chinese believe that, if one follows Confucian teachings closely, and avoids excessive and incongruent emotions, mental disturbances should not occur. Confucianism also teaches that maintaining harmony in familial and social relationships requires inhibition and avoidance of emotional expression. Thus, the logical suppression of emotions and the taboo against discussing one's feelings can be seen as psychocultural coping mechanisms (Yeh, 1972, p. 132).

- ***Genetic factors***

Belief in the cyclic phases of birth, death and reincarnation influences the Chinese to consider both physical and mental illness as genetically transmittable. This belief is often demonstrated by the common practice of searching back three generations into the family history of a potential son or daughter-in-law by the potential parents-in-law, in order to rule out any "bad seeds" in the family (Li, 1984).

Current help-seeking behaviour

In a Vancouver study, Dr. T.Y. Lin identified five phases of the help-seeking pattern of mentally ill Chinese and their families in Canada (Lin et al., 1978, p. 3). These five phases, extending from the onset of the illness to eventual hospitalization, are:

1) Exclusively intrafamilial coping;
2) Inclusion of certain trusted outsiders in the intrafamilial attempt at coping;
3) Consultation with outside helping agencies, physicians and finally a psychiatrist while keeping the patient at home;
4) Labelling the problem as a form of mental illness, and a subsequent series of hospitalizations;
5) Scapegoating and rejection.

Different factors contribute to such a help-seeking pattern. Traditional cultural negativism regarding mental illness is one of the major factors. Because of traditional perceptions of mental illness, mentally ill patients are seen as a disgrace, and thus become family secrets. Exposure would negatively affect the prestige of the family. The face-saving factor results in the concealment of the patient, and the illness is denied proper care. Minor mental disorders are often viewed as being caused by one's deviation from the major philosophical teachings or from physiological homeostasis. Only those suffering from the major mental illnesses, i.e. psychoses, are accepted as mentally ill (Li, 1984). The head of the family is usually the one who assumes the responsibility for the treatment modality and its implementation. His choice of treatment modality depends on his philosophical and religious beliefs, but herbal medicine is almost always used. It is only when the family members have exhausted their resources and their treatment modality has proven ineffective that they turn to the professionals. Studies (Lin and Lin, 1978; Wong, 1978) have indicated that an extended delay in seeking help from psychiatric institutions is universal for Chinese psychiatric patients, and such practices have led to numerous chronic psychotic cases in this patient group. For new Chinese immigrants, the language barrier and the relative lack of information about public services are also obstacles that delay proper care at an early stage (Li, 1984).

Recommendations and conclusion

Cultural values are most important in determining the health beliefs and practices of an individual. Cultural values act as the blueprints for human health behaviours. They determine what cultural groups will do to maintain their health status and the quality of care that those who become ill will receive (Leininger, 1978, p. 39).

Practitioners must take into consideration the values, beliefs, and customs of patients and their significant others. When working with mentally ill patients of another ethnic origin, the practitioner should maintain a broad, objective attitude and not be misled into assuming that the colour of their skin determines their culture (Leininger, 1978, p. 87). While there are common features and cultural characteristics, it is important for the practitioner to give individualized patient care rather than making the assumption that everyone is similar. A cultural assessment tool, such as the one developed by Davies and Yoshida (Figure 1) can assist the practitioner in accomplishing this goal.

For the practitioner who understands the cultural perception of mental illness, it is not difficult to recognize that stigma is a major problem that the mentally ill Chinese Canadian and his/her family must face every day. Reassurance of confidentiality can be psychologically soothing for the patient and the family. Furthermore, better utilization of community resources, such as the Greater Vancouver Mental Health Service in Vancouver, B.C. and the Hong Fook Mental Health Association in

Figure 1

Important factors to consider

- A. Country of origin
  - I) Historical background
    - a) Ecology (e.g. climate, geography)
    - b) Social structure (e.g. education, politics, kinship, religion, health care)
- B. Receiving country
  - I) Similarities and differences of receiving country to country of origin
    - a) Language, skin coloring and way of dress
  - II) Importance of peoples from same country of origin to new immigrant
- C. Individuality
  - I) Reasons for emigration
  - II) Adaptability to change
  - III) Acculturation

- Values, beliefs and practices of new immigrant

Reproduced with permission from "A Model for Cultural Assessment of the New Immigrant" by M. Davies, and M. Yoshida. 1981. *Canadian Nurse*, 77(3), p. 22.

Toronto, might prevent or reduce the need for hospitalizations. This would ease the family's stress of having a "crazy" family member being "locked" in a mental institution.

Genetic counselling can be helpful for patients who firmly believe that mental illness is transmitted from generation to generation. Practitioners must be sensitive to the shame and guilt feelings of the older family members of the patient, because they may have the belief that their behaviour in the past has caused the illness. Involvement of the family, especially the male head of the household, should be encouraged.

A thorough assessment of the patient's previous treatment modality should be carried out before any medication is prescribed, for most Chinese families would use Chinese herbal medicine on the patient despite other treatment plans designed by the professionals.

Due to their philosophical teachings, Chinese patients and their families usually have difficulty discussing their problems or expressing themselves emotionally, especially in an alien tongue. Practitioners should not consider such behaviour as depression or as a sign of uncooperativeness. We should respect their practices and rituals; however, alternatives should be offered at the same time. Health teaching of topics such as the etiology of mental illness, medication, nutrition and effective communication are particularly helpful. Trust can be gained when the family is convinced that the practitioner understands their psychological suffering and their cultural heritage. An interpreter who is knowledgeable in the Chinese culture and fluent in the patient's mother tongue would be invaluable in the treatment of this group of patients.

Incorporating instruction about social structures, cultural systems and transcultural human services into mental health education and in-service programs can be the beginning of our attempt to assist mentally ill persons from different ethnic backgrounds.

We cannot guarantee a thorough understanding of each ethnic group within our multicultural mosaic, but we can take steps to guarantee our sensitivity to their needs and to demonstrate our sincerity in helping them on the road to recovery.

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Asian Americans and Rehabilitation: Some Important Variables

**By Paul Leung, and
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Rehabilitation counselors will come increasingly into contact with Asian Americans as part of their workload. This article describes and discusses the Asian Americans with the purpose of setting aside myths and stereotypes as well as providing some information helpful to understanding the Asian Americans within the rehabilitation process.

In his landmark work on rehabilitation, Wright (1980) pointed out the importance of cultural variables in the rehabilitation process. Especially underscored was the need for rehabilitation counselors to recognize the negative effects of stereotyping and culture bound attitudes (Wright, 1980).

Rehabilitation practitioners will increasingly encounter Asian Americans who are in need of rehabilitation services, as well as those who will, as fellow professionals, work side-by-side with them in providing rehabilitation services. It should be noted from the outset that there are counselors practicing in major metropolitan areas, such as Los Angeles, Seattle, Honolulu, and New York City who have already encountered and provided services to Asian Americans and who are quite familiar with the rehabilitative needs of this segment of the American population. This paper is intended more for those counselors who have yet to have extensive experience with serving the Asian American.

The reader might speculate why the need for this paper given the awareness of the multiethnic and multicultural nature of American society. However, there seems to be no lessening of racism, prejudice and discrimination despite the extended presence of Asian Americans in the United States since the 1800s. The stereotyping and expectations of Asian Americans by the larger majority in the United States is particularly significant because of the relatively small numerical size of the Asian American population in relationship to the majority population. The vast majority of the American population has had very little contact with Americans of Asian descent and many times what contact occurs is only through the popular media. Even now television, movies and advertising continue to portray Asians with heavy accents and pigtails, or as Charlie Chan, mysterious and inscrutable, or as Suzie Wong, an exotic sex object. At the other extreme, Asian Americans have been pitted against other minority groups and held up by the majority to be the "model" minority able to succeed and to achieve.

The purpose of this article is to introduce the reader to the current status of the Asian American population. It is hoped that the result will be an understanding by rehabilitation practitioners of Asian Americans and a sensitivity in serving them. Just as increasing numbers have made Asian Americans more visible in the political arena (*Wall Street Journal*, 1988), Asian Americans are becoming more visible in rehabilitation programs. Some of the variables that have impact on perceptions of Asian Americans as well as those variables that have had influences on Asian Americans today are discussed.

Fast Growing Minority

Americans of Asian descent are the fastest growing minority group in the United States both from births by residents and through continued immigration. One and a half million or .8% of the population were of Asian or Pacific Island descent as identified by the 1970 census. By 1980, the census count was 3.7 million and 1.6% of the total population. During the past year, in California, Asians surpassed the number of blacks making up 9.3% of California's population (*Asian Week*, 1988) Another significant factor in the growth of the number of Asians is the admission of large numbers of refugees from Southeast Asia. One estimate has this number at about 4,000 per month (U.S. Commission on Civil Rights, 1986). The distribution of Asian Americans in the United States is uneven The 1980 census shows that 60% reside in three states: California, Hawaii, and New York. The majority of the Asian American population is concentrated in the West where they make up 5% of the total population and in the Northeast where they constitute 1.2% of the total.

Diversity

It is significant that Asian Americans are not a homogeneou group even though it is often said that one cannot "tell them apart." This is even more evident when Pacific Island people are included. It has been suggested that the category Asian American and Pacific American includes at least 32 distinc ethnic or cultural groups. In alphabetical order they are Bangladesh, Belauan (formerly Palauan), Bhutanese, Burmes Chammorro (Guamanian), Chinese, Fijian, Hawaiian

H'mong, Indian (Asian or East Indian), Indonesian, Japanese, Kampuchean (formerly Cambodian), Korean, Laotian, Malaysian, Marshallese (of the Marshall Islands, which include Majuro, Ebeye, and the U.S. Missile Range, Kwajalein), Micronesian (of Federated States of Micronesia, which include Kosrae, Ponape, Truk and Yap), Nepalese, Okinawan, Pakistani, Filipino, Saipan Carolinian (or Carolinian from the Commonwealth of the Northern Marianas), Samoan, Singaporian, Sri Lanka (formerly Ceylonese), Tahitian, Taiwanese, Tibetan, Tongan, Thai, and Vietnamese (Wong, 1982).

The ethnic and cultural differences are complex and great between these groups. Not only are there vast geographical distances between the many countries cited earlier, but language and an ancient cultural heritage rich in unique customs and traditions separate these various populations as well. It would be misleading to lump them together as one homogeneous group.

Historical Experience

Asians have been in the United States since the early 1800s. Some would argue that their presence would predate that to the much earlier time when a land bridge connected the two continents. Regardless, Asians have faced persistent racial discrimination since their arrival, with restrictions on their entrance not lifted until 1965. For example, the Chinese Exclusion Act was passed by Congress in 1872 and reinstated in subsequent years which prevented the immigration of the Chinese. And in 1924, wives of Chinese males already in the United States were specifically barred from entry.

Other discriminatory events included the humiliation and incarceration of the American citizens of Japanese descent during the Second World War. Then President Franklin Roosevelt signed an executive order authorizing the detention of Japanese Americans in relocation camps. No other minority group which manifested peaceful coexistence has experienced similar treatment in U.S. history.

Current Discrimination

The third and fourth generations of Asian Americans still carry the onerous hyphenated label of Asian-American. Present day immigrants from Europe or Great Britain are not categorized in the same manner. More recent immigration by the South Koreans to the United States has again perpetuated the "need" to provide them with a hyphenated label, Korean-American. In another curious twist of cultural logic, the Tongans, Samoans, and Fijians do not suffer the same hyphenated labeling; but nevertheless, suffer similar exclusionary, outgroup status. Social psychological theory of cognitive consistency seems to provide some basis for understanding the need for labeling (Kitano, 1973).

There have been a number of incidents in the past few years indicating that overt discrimination continues against Americans of Asian descent. The beating death of Vincent Chin, a Chinese American, in Detroit in 1982, was the result of two laid-off automobile workers believing Chin to be Japanese and blaming Chin for what has happened with the automobile industry. Other incidents of a more current nature include problems between Vietnamese fishers and other fishers in the Gulf areas, tensions between Korean businesses and other residents in the Los Angeles and New York areas, and the death of a Chinese American woman pushed into a subway train in New York by a man who said he had a "phobia about Asians." Though often touted as a minority group that has achieved, these events clearly indicate that discrimination against Asian Americans is not a thing of the past.

Noting that racism persists, the most benign form seems to be racial tolerance and passive discrimination. Kitano (1973) theorizes that discriminatory behavior by a "normal" group can be understood by its relationship to a cohesive, identifiable subculture and the resultant restrictions (real or assumed) of their outgroup interactions. He contends that the insulation of subgroups in our pluralistic society provides a perhaps unwanted, but nevertheless powerful structure that fosters discriminatory behavior against outgroups. The person who is fully integrated into a subculture is the person most likely to discriminate. The person less fully integrated into the subculture is less likely to discriminate.

Model Minority?

Perhaps the most prevalent view of Asian Americans is that they have made it. An initial look at the statistics would seem to bear this out. The mean earnings for workers of Asian descent between the ages of 25 and 54 are essentially at parity with whites. The mean income for Japanese American males in 1979 was about 10% higher than for white males. Korean, Chinese, and Filipino males of Asian descent had incomes of 96%, 90%, and 86% of whites. The one group with lower earnings is the Vietnamese with an income level averaging 57% of the white majority. With regard to occupational level, Asian Americans would also seem to have done well. Almost 13% of Chinese and Japanese Americans were executives or managers compared with 11% of whites. However, the figures for Korean Americans were 9.9%, for Filipinos it was 7.7%, and only 4.5% of Vietnamese.

But another real and contrasting view of the Asian American provides a different and distressing picture. The poverty rates for Chinese, Korean, and Vietnamese are considerably higher than for the white majority. Ten and a half percent of Chinese, 13.1% of Korean, and 35% of Vietnamese families are in poverty compared with 6.6% of the white population. Poverty status of the Vietnamese is the lowest nationally (Fujii, 1980).

With the often assumed strong motivation toward high educational achievement by all Asian Americans, the reality of differential achievement is sobering. In spite of high math and science achievement, Sue (1981) cited a study in which 50% of entering students of Asian descent to the University of California at Berkeley did not pass the "bonehead" English examination. Asian American students were twice as likely as whites to fail the English examination. A study in New York City (*Insight*, 1988) found that 17,500 students of Asian descent fell below the cut-off for adequate English language proficiency. This number was about 30% of the overall school population of 57,631 Asians. In the same *Insight* (1988) article, Shirley Hune, an associate professor in educational foundations at City University of New York was quoted as saying, "The stereotype is that all Asian students are excelling. The result is that teachers and society fail to pay attention to them. Those in need are passed over because we are led to assume all is well."

Another problem area of concern in contemporary American society is drug use. What little data are available regarding Asian Americans seem to indicate drug abuse to be problematic. A report released by the Seattle King Country Drug Commission stated:

> The evidence presented . . . suggests that drug use within the Asian youth community is much more serious than what is recorded by law enforcement agencies or indicated by the policies of drug treatment programs . . . Asian youth appear to use drugs at a level equal to if not higher than the national average . . . known users tend to begin the use of drugs earlier and continue in a manner and extent far above the national average. (Washington State Commission, 1983, p. 115)

Finally, a recent article appearing in *Asian Week* (1988) highlighted the problems of Southeast Asian immigrants and refugees. These include the severe disintegration of the family structure which forces many Southeast Asians to adopt lifestyles in conflict with their traditional life experience. The results include high divorce rates, family problems especially of the young who have little supervision from parents preoccupied with survival, and incidence of domestic violence.

The idea that Asian Americans are a model minority is a myth. Believing that Americans of Asian descent have made it and do not need help can interfere with providing the necessary support and services to which all Americans are entitled.

Generational Status and Recent Immigration

Ethnic and cultural diversity among the numerous Asian American groups stretches beyond categorization. Each subgroup possesses a number of unique characteristics which should be considered if one is to have understanding of and sensitivity toward that group. More generally, however, there are characteristics, in addition to some of the historical experiences alluded to earlier, which may be useful in understanding a member from any of the subgroups.

Generational status is an important variable to consider in working with a particular individual or family. This refers to the time which the person or family has been in the United States. A fourth generation Asian American has obviously different perspectives of self, culture, etc. than a new immigrant or refugee. This is true for perspectives on family structure as well as the reliance upon support systems.

As with immigrants from Europe, the first generation Asian Americans show greater affinities for ethnic traditions, customs, and methods for dealing with sickness and adversity. The next generation, those born in the United States, show greater acculturation and attenuation towards white, middle-class standards and expectations. The third generation show a further attenuation, but one which appears more ready to confront issues of inequality.

The older generations, i.e., those who immigrated in the late 1800s to early 1900s, represent a small and diminishing group of individuals who are rural in background and not well educated. These elderly are more likely to rely on the traditional ethnic community as the primary resource. More recent immigrants are likely to be middle class and more demanding of services from the greater community.

Recent immigrees, such as the Hmong from Southeast Asia, experience more keenly stressors such as a breakdown of the car, homesickness, lack of information on medical services, loss of job and communication problems at work, and unpleasant work experiences. It seems the more recent the immigration and the smaller the supporting ethnic community, the greater the stress reaction.

The more recent the immigration to the United States, the greater the anxiety about dealing with unknown governmental procedures and the resultant reluctance in requesting needed public services. It appears that many of the Asian Americans with disabilities do not identify themselves out of fear of dealing with governmental agencies.

Though acculturation or more specifically, Westernization, is often cited as an important element in understanding where a person is and how they would describe their values, etc., it is not always linked to generational status. An illustration of this would be a person born in the United States, but due to whatever circumstance lives in a traditional ethnic community insulated from outside contact.

Within any given group, there may be additional differences important to understanding individual and family attitudes and perceptions (Lee, 1982; Smith, 1985). Although Chinese by descent, a person or his forebearers might have come from many different areas not only in China but also from other Asian countries.

Variations in the use of one's "native" language and one's competence and comfortableness in doing so may be an important factor in fostering communication and successful rehabilitation. The difficulty of translated concepts between languages has often been cited as problematic in health care settings. Rehabilitation would be no different. Fluency in English and skills in communication are not exclusively tied to American-born Asians, it is often the case that apparent limitations can be found among the second generation, i.e., those born in the United States.

While educational achievement would appear to be a clear cut prediction of social competence, it is critical to know not only the level of education attained but also where that education was obtained. Whether or not the education was obtained in the United States or in Asia may be vital to understanding and being sensitive to particular styles of thinking and problem solving.

Attitudinal Differences

The differences between white and Asian American students are important to our understanding of the unique help-seeking process of Asian Americans. However, previous comparison studies (Tracey, Leong, & Glidden, 1986) seem to imply that all Asian Americans are alike, that is, that Chinese Americans are similar to Japanese Americans, both of whom are similar to Filipino Americans. This uniformity myth may have some value when whites are the standard of comparison, but each of the Asian American cultures is quite distinct. Asian Americans are often not only not collective, but are subgroups of Chinese Americans or Japanese Americans. Analyzing all Asian

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Americans together neglects important self-identified differences among the various Asian cultures (Sue & Kirk, 1973; Kuo, 1984) as resources to better understand Asian cultural differences.

Potentially negative social and political attributions have an impact on accessibility and service delivery that is often overlooked. That some Chinese Americans have an affiliation with the anticommunist movement or to have current ties with the Taiwan government versus any identification with mainland China can affect our understanding of them.

Use of Health Resources

Local community networks, whether formal or informal, are important. For first generation immigrants, traditional family associations often wield considerable power in choice and access to health and rehabilitation resources. The organized formal churches where ethnic groups congregate are important for information exchange and knowledge about resources. Informal networks such as "majong" groups that congregate daily or weekly may be useful in education, etc. Ethnic media, newspapers, radio, or television also affect perceptions and attitudes.

The search for relevant health or mental health services first takes place within the local ethnic community, based upon kinship and local associations, it is only when these resources within the ethnic community are exhausted that the older Asian is forced to seek outside public services, interaction with the outside, greater community limits access or utilization of available services.

Within any particular Asian group in the United States, there are a considerable number of factors that influence its members in seeking rehabilitation services. Even among new arrivals, their particular status as either immigrants or refugees may be important. As Liu (1987) has indicated, there are subtle or sometimes not so subtle influences. Refugees may experience an "acute flight" situation where there was little preplanning and they may have entered the country with little knowledge of the destination. On the other hand, immigrants may have spent some time learning about their destination and learning skills that will be needed for successful adaptation.

Age may be another factor of importance. For example, in working with older persons, the professional must be cognizant of the client's frame of reference. Traditions, customs, etc. need to be explored with the client and the support person(s). Diet preferences, mode of hospital dress, propriety of interview techniques, perception of the sick role, are subtleties in variables which need to be integrated as part of the rehabilitation process. The rehabilitation practitioner might do well to seek the assistance of someone the client trusts and who can facilitate communication. Many elderly are confused by self-directed decision making and choice selection and rely heavily on medical authority. Clients often view health professionals as ineffective if the client is left with the decision making. Authority by role and professional status are relied upon for decision making.

Rehabilitation professionals need to understand that Asian American clients and their families in fact have many differences among them. These differences are not easy to recognize, to even catalog or inventory, but knowing that they are there may be equally as important in successfully working with this particular population as the treatment itself. That basic psychological tenet of not generalizing and working with the individual becomes that much more important. The rehabilitation professionals may need to understand their own attitudes and feelings along with their expectations and perceptions of Asians.

In summary, rehabilitation counselors and rehabilitation practitioners who work or plan to work with Asian Americans with disabilities need to understand the diversity of Americans of Asian descent and not attempt to treat them all in the same manner. It is helpful for rehabilitation counselors to be aware of the historical experiences of Asians in the United States and the discrimination they continue to face if rehabilitation counselors are to be sensitive to their Asian American clients' needs. Finally, in spite of the progress that Asian Americans have made, this progress is not reflected equally either in all the Asian American populations or often within each group and rehabilitation counselors would do well not to dismiss Asian Americans as having the capability of solving their own problems. Given a single Asian American ethnic group, its within-group differences in response to severe disability will vary according to status as recent refugees, elderly naturalized citizens and U.S. born citizens all will show differences in the effects of acculturation or Westernization, assimilation, and ethnic identity. Much more research regarding the impact of disability on Asian Americans and ways to work effectively with them is needed. The contemporary Asian American, in contrast to the traditional, stereotyped image, is not well known and difficult to describe. However, rehabilitation practitioners will be increasingly called to provide rehabilitation to Asian Americans. Recognition of Asian American traditions, the individual and family forces impacting on them, their world view and their use of human services will bring about a more effective practitioner.

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HISPANIC WOMEN AND MENTAL HEALTH

An Overview of Contemporary Issues in Research and Practice

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In 1985, there were 8.5 million Hispanic[1] women in the United States – 1 of every 17 women. It is estimated that by the end of the 20th century, Hispanics will be the largest U.S. minority group (Bureau of the Census, 1981a). The rapid growth rate of the Hispanic population reflects a combination of its younger age (so that a larger proportion of women are in

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childbearing years), its higher fertility rate, and continuous migration from Mexico, Puerto Rico, and other Latin American countries.

Mental health policymakers have begun to recognize the importance of developing culturally sensitive mental health services for the rapidly growing Hispanic population (Subpanel on the Mental Health of Hispanic Americans, 1978; Task Force on Black and Minority Health, 1986). However, the gender bias that pervades mental health theory, research, and practice (cf. Russo, in press, for a review) is mirrored in mental health services designed to reach Hispanic populations. Furthermore, arguments that therapeutic activities and structures should reflect Hispanic culture have been used to reinforce stereotypical sex roles (Rogler, Malgady, Costantino, & Blumenthal, 1987), and have failed to recognize the realities of contemporary Hispanic women's lives.

A new scholarship on the psychology of Hispanic women is emerging – a scholarship that recognizes the reality and diversity of Hispanic women's attitudes, behaviors, roles, and circumstances. Researchers have begun to challenge the stereotype that all Hispanic women and men hold rigid conceptions of sex roles (Andrade, 1982; Hawkes & Taylor, 1975). As Vazquez-Nuttall, Romero-Garcia, and De Leon (1987) point out in their review of the literature, education and urban background have long been recognized as important influences on the sex roles of Puerto Rican women within the family (Stycos, 1955). These authors note that more recent work on other Hispanic populations has examined the effects of acculturation, education, and labor force participation on Hispanic women's attitudes, roles, and status. They conclude that the changes in roles of Hispanic women cannot be attributed primarily to acculturation. They also found that Hispanic women's increased education and labor force participation do not have homogeneous effects in changing sex roles and the distribution of power in Hispanic families. Their work documents the need to explore the relationships among attitudes towards gender and sex roles and personality traits and behaviors. Clearly, much needs to be learned if we are to understand the mental health consequences of the changes in Hispanic women's lives and circumstances (Andrade, 1982; Hawkes & Taylor, 1975; Russo, Amaro, & Winter, 1987).

While Hispanics as a group share some common cultural and linguistic characteristics, the umbrella term "Hispanic" is applied to groups with distinct historical, political, economic, and racial differences. The immigration and migration processes of these groups are distinctly different and have direct bearing on the economic, social, and political characteristics of each Hispanic group. While a complete review of the multiple factors affecting the status of various Hispanic groups in the United States is beyond our scope, the reader is referred to the excellent book by Moore and Pachon (1985) entitled *Hispanics in the United States* for an introduction to these issues.

The grouping of Mexican-Americans, Puerto Ricans, Cubans, and individuals from other Latin American countries and Spain in the gathering and reporting of data can produce misleading findings and lead to erroneous conclusions. For example, policymakers interested in increasing Hispanic access to health care might develop very different strategies if they had access to more research that examines differences among Hispanic groups. Some findings suggest that Cuban Americans and Puerto Ricans make more physician visits than either Whites or Blacks, while Mexican-Americans make fewer visits than any group (Trevino, 1986). Obtaining an accurate picture of Hispanic women's physical and mental health in the various Hispanic ethnic groups will require substantial changes in both data collection and dissemination methods on federal and state levels.

In addition to scientific concerns about the generic category "Hispanic," there are political concerns about the use of the label as well (for a review of the scientific and political arguments on terminology referring to Hispanic populations, see Hayes-Bautista, 1980; Hayes-Bautista & Chapa, 1987; Trevino, 1986, 1987).

Unfortunately, most instruments use the term "Hispanic" to gather data on the use of mental health facilities, as do mental health policy analyses that examine ethnicity (e.g., Rosenstein, 1980). We have also used the term here, as it is most generic and most widely in use currently, but do so only with recognition of its limitations (Hayes-Bautista, 1980; Hayes-Bautista & Chapa, 1987; Trevino, 1986, 1987).

Why Focus on Mental Health?

We have chosen to focus this special issue on Hispanic women's mental health for several reasons. The first is professional responsibility. Gender and sex role biases in psychological research and practice have enabled psychology to be used to support the status quo – which means a disadvantaged status for women (Russo & Denmark, 1984). Lack of knowledge about the psychology of Hispanic women means that stereotypes rather than realities have influenced the design of mental health policies, research, and services.

A second reason for focusing on mental health is the critical need to provide information to supplement recent policy documents focusing on minority and women's mental health. Two recent publications, *Report of the Secretary's Task Force on Black and Minority Health* (Task Force on Black & Minority Health, 1986) and *Women's Mental Health: Agenda for Research* (Eichler & Parron, 1987), have established a favorable policy context for research on the mental health of minority women. Both reports lack specific coverage of Hispanic women's issues. Thus visibility for such issues assumes greater importance. We hope that this work on the mental health of Hispanic women will serve as a catalyst for policy initiatives that will stimulate new research as well as new models of mental health treatment and service delivery.

The third reason for a mental health focus is the current tension between academic researchers and clinical practitioners in the field of psychology. We believe that the combination of research and clinical articles presented here demonstrates the benefit of mutual cross-fertilization of research and practice. The articles in this issue approach their subject matter from different perspectives and include epidemiological data as well as clinical insights. Contributors include clinical, developmental, and social psychologists; psychiatrists, sociologists, epidemiologists, and statisticians. Since understanding women's mental health requires examination of the interaction of biological, psychological, social, and cultural variables, divisiveness among subfields of psychology and competition across disciplines can detract from the advancement of knowledge, the application of research findings, and the development of services based on empirical study rather than personal impressions.

Finally, it is hoped that a focus on mental health will be a step toward remedying the lack of information on the psychology of Hispanic women in the education and training of psychologists. Although the accreditation criteria of the American Psychological Association require responsiveness to issues of gender, ethnic, and cultural diversity in clinical, counseling, and school psychology doctoral programs, there has been little attempt to incorporate scholarship on Hispanic women into graduate and undergraduate programs in psychology. Greater accessibility to new scholarship on Hispanic women is needed to facilitate curriculum integration efforts. We have developed a selected bibliography of the social science literature that should prove useful in this regard (Amaro, Russo, & Pares-Avila, 1987).

HISPANIC WOMEN: THEIR SOCIAL AND ECONOMIC CONTEXT

To understand mental health issues for Hispanic women, it is necessary to appreciate the social and economic contexts that shape the realities of Hispanic women's lives. The demographic picture for Hispanic women differs depending on Hispanic ethnic group in psychologically significant ways that merit attention by mental health scientists, professionals, and policymakers. According to the March 1985 Current Population Survey (Bureau of the Census, 1985b), Hispanics living on the U.S. mainland have the following backgrounds: Mexican (61%), Puerto Rican (15%), Cuban (6%), and other Central and South American countries and Spain (18%). The latter group is comprised of a growing number of individuals from the Dominican Republic, El Salvador, Honduras, and Guatemala, many of whom have emigrated for political reasons. Unfortunately, demographic data are not consistently available on the various groups that comprise this group of Hispanics. There has been little work on the differences and similarities among Hispanic groups in general, let alone specific study of variables related to gender and sex roles (Vazquez-Nuttall et al., 1987).

Special difficulties are found in the collection and reporting of information on Puerto Ricans. Census information and health statistics typically focus on the U.S. resident population, which includes only residents of the 50 states and the District of Columbia. The over 3 million individuals who reside in the U.S. Commonwealth of Puerto Rico are thus not included in the decennial census reports. Psychological research involving island Puer-o Ricans is also scarce, so that little information about this specific His-anic group is available. The work by Canino and her colleagues with this opulation (1987) is a notable exception.

As Salgado de Snyder (1987) and Espin (1987) point out, the experiences f migration and immigration have significant mental health implications. While migration/immigration and cultural adaptation issues are impor-ant for all Hispanic groups, the proportion of individuals not born in the ontinental U.S. varies among them. The majority of Mexican-Americans 75%) are born on the U.S. mainland. In contrast, most Puerto Ricans 55%), Cubans (75%), and Central or South Americans (64%) are born lsewhere (Moore & Pachon, 1985).

Regional issues must be taken into account, particularly when discussing ervice delivery issues. Hispanics live in every state, but are concentrated n the Southwest (Mexican Americans), Northeast (Puerto Ricans), and outheast (Cubans) (Bureau of the Census, 1981c). Urban issues affect a arger proportion of the Hispanic population than the Anglo population. Puerto Ricans (97%), Cubans (97%), and Mexican-Americans (85%) are more likely to live in metropolitan areas than Anglos (74%) (Bureau of the Census, 1985b), and urban residence has also been found to be associated with higher rates of symptomatology (Canino et al., 1987).

Espin (1987) points out the critical role that the ability to switch back and forth between English and Spanish can play in therapy. While not all Hispanics speak Spanish, it is estimated that over 11.5 million people in the U.S. (5% of the nation's population) speak Spanish in the home (Moore & Pachon, 1985).

As Russo, Amaro, and Winter (1987) point out, age is significantly related to the etiology and diagnosis of mental disorder, as well as to the utilization of mental health services—and its effects vary with gender and diagnosis (Lewine, 1980, 1981; Rosenstein & Milazzo-Sayre, 1981; Russo & Olmedo, 1983; Russo & Sobel, 1981). As a group, Hispanic women are younger (median age = 26 years) than females in the general U.S. popula-tion (median age = 32 years). However, there are large differences in age distribution among Hispanic groups. Mexican-American women are the youngest (median age = 24), followed by Puerto Rican women (median age = 26), and Central/South American women (median age = 28). Cuban women (median age = 41) are older than all other Hispanic groups, and are even older than Anglo women (median age = 33) (Bureau of the Census, 1985c). Given the differences in rates of utilization of mental health services over the life cycle, the marked age differences among ethnic groups have important implications for the design of mental health ser-vices.

of Hispanic women were government and salary workers, the majority (13%) in state and local government (Bureau of the Census, 1983).

The association between income and psychological disorder is well established (Amaro et al., 1987; Belle, 1984; Cleary & Mechanic, 1983; Ross & Huber, 1985). Hispanic women earn lower wages than Anglo women. In 1984, Hispanic women earned an annual income of $5,830 compared with $6,949 for women overall. Puerto Rican women have the lowest annual income ($4,985), followed by Mexican-American women ($5,781) and Central/South American women ($6,212). Cuban ($6,861) and "other Spanish" ($6,932) women earned about the same as U.S. women overall (Escutia & Prieto, 1986).

In addition to having low individual incomes, Hispanic women frequently live in poor families. In 1984, Hispanic families had a median income of $18,833, compared to $27,686 for Anglo families (Bureau of the Census, 1985a). Puerto Rican families are the poorest, earning 46% of nonHispanics, followed by Mexican-American (71%) and Cuban (85%) families (Bureau of the Census, 1985b).

Since Hispanics have larger families, their mean income per family member is lower than that for all families. In 1981, Hispanics earned $4,981 per family member, compared with $7,941 for all families (Bureau of the Census, 1983).

Poverty has been found to be so destructive to women's mental health that it has been identified as one of the priority areas for the Women's Research Agenda of the National Institute of Mental Health (Eichler & Parron, 1987). In 1984, 25.2% of Hispanic families lived below the poverty level, compared with 9.1% of Anglo families. Puerto Rican families are the poorest, with 42% of families below the poverty line, compared with 24% of Mexican-American or Central South American families, and 13% of Cuban families (Bureau of the Census, 1985b).

Women who are single heads of households, particularly divorced and separated women, have been identified as at high risk for stress (Miller, 1987; Thoits, 1987). In 1984, 23% of Hispanic families were headed by women, compared with 12.8% of Anglo families. Puerto Ricans had the highest proportion of families headed by women (44%), followed by Central South Americans (21.9%), Mexican-Americans (18.6%), and Cubans (16%). Furthermore, Hispanic families headed by women are more likely (53.4%) to fall below the poverty level than Anglo families (27.1%) (Bureau of the Census, 1985a, 1985b).

Family Size and Composition

Two significant demographic developments in the 1970s were the increases in the proportions of never-married and divorced (Bureau of the Census, 1981b). In 1981, 22.5% of women and 29.4% of men 15 years and older were never married; for Hispanic women and men, the figures were 26%

and 34%, respectively. For women and men ages 30-34, 10.4% and 16.4% were never married; for comparable Hispanic women and men, the figures were 10.5% and 13.5%.

Also in 1981, 9.8% of women and 7.2% of men were separated or divorced; for Hispanics, the figures were 14.1% and 6.5%. That year only 52.6% of Hispanic women 15 years of age or older were in families with a husband present. It is unfortunate that the stereotype of the traditional Hispanic woman, married and devoted to home and family, has led to a lack of knowledge about the large numbers of Hispanic women who do not conform to the traditional family model. Given that one in seven Hispanic women over age 15 is separated or divorced, and thus at high risk for psychological distress if not disorder, the lack of research on the mental health effects of marital dissolution on Hispanic women is of particular concern.

Having children at home has been found to contribute to depressive symptomatology (Cleary & Mechanic, 1983), particularly under conditions of economic hardship (Ross & Huber, 1985), and stress related to parenting has significant mental health implications (Eichler & Parron, 1987). Hispanic fertility is higher than nonHispanic fertility. In 1984, the fertility rate (number of births for every 1,000 women aged 15-44 years) for nonHispanic women was 64.3; for Hispanic women it was 91.5. "Other Hispanics" (Central and South American, and other and unknown Hispanic origin) had the highest rate (109.6), followed by Mexican-Americans (95.8), Puerto Ricans (65.6), and Cubans (44.7) (Ventura, 1987).

Teenage childbearing has been linked to a variety of psychological, social, and economic problems (Hayes, 1987; Russo, 1986). Hispanic women are more likely to begin childbearing in their teenage years compared with nonHispanic women. Teenage births accounted for 18% of births to Mexican-American mothers and 21% of births to Puerto Rican mothers in 1984. The comparable figure for nonHispanics was 12%. Cuban mothers are the exception – only 8% of Cuban births were to teenagers, which reflects the tendency of Cuban women to be older than other Hispanic groups.

In 1984, an estimated 28% of Hispanic births were to unmarried mothers. The proportion varies widely by ethnic group: 51% of Puerto Rican, 34% of Central and South American, 24% of Mexican-American, and 16% of Cuban births were to unmarried women. In contrast, 11 percent of white nonHispanic births were to unmarried women (Ventura, 1987). Births to unmarried mothers, particularly teenagers, are likely to be unplanned and unwanted (Hayes, 1987; Russo, 1986). The prevention of unwanted childbearing has been suggested to be a critical strategy for primary prevention of psychological distress and mental health problems (Russo, 1985).

In summary, the economic and social circumstances of Hispanic women vary among Hispanic groups, and differ from Anglo women. Hispanic women as a whole, however, are overrepresented among lower socioeconomic classes and younger ages. Thus it is important to control for economic, social class, and age differences before attributing Hispanic/Anglo differences in attitudes and behaviors to differences in cultural values. All too often, acculturation and "Hispanic cultural values" are invoked to explain behaviors without consideration of more proximal economic, social, and life cycle variables that could be influencing the behaviors as well.

BASIC ISSUES IN MENTAL HEALTH RESEARCH AND SERVICES

Service Access

Reports on Hispanic mental health have underscored access to services as a basic issue (Subpanel on the Mental Health of Hispanic Americans, 1978; Task Force on Black & Minority Health, 1986). Epidemiological analyses of utilization statistics have suggested that Hispanics are admitted to mental health facilities at lower rates than Whites or Blacks (Rosenstein, 1980). Russo et al.'s (1987) description of Hispanics' use of inpatient mental health facilities emphasizes the importance of examining gender differences in utilization patterns. They point out that when the currently available survey data on utilization of inpatient mental health facilities are examined by ethnicity and gender, Hispanic women appear to account in large part for the underrepresentation of Hispanics in these facilities. While the extent to which underrepresentation of Hispanics is due to unreliability of measurement, difference in prevalence, differential marriage and divorce rates in response to mental disorder, differential help-seeking, or other factors is not known, the findings are suggestive and underscore the great need for research on mental health issues for Hispanic women.

Cultural Sensitivity of Services

Feminist criticism of psychotherapy as a form of social control has been well established in the psychological literature (cf. Carmen, Russo, & Miller, 1981; Subpanel on the Mental Health of Women, 1978). The use of psychotherapy to promote social control of Hispanic women deserves similar criticism. It was not until feminist Hispanic psychologists began to redefine the issues and develop therapeutic alternatives that the preservation of *traditional* cultural elements in the design of mental health services began to be questioned (Boulette, 1976; Canino, 1982). Cultural sensitivity should incorporate a recognition of the changes in Hispanic women's roles and circumstances (Vazquez-Nuttall et al., 1987), and should not reinforce a disadvantaged social and economic status for such women. The articles by Espin (1987) and Comas-Diaz (1987) are particularly helpful in this regard.

Gender Roles and Depression

Canino and her colleagues (1987) point out that both clinical and community studies of Anglos and Hispanics have consistently reported a higher rate of depressive symptoms and depressive disorders in women compared with men, and the rate of depressive symptoms is higher in women regardless of acculturation level. They review the literature on sex differences in depression, and report results from their survey of the prevalence of depressive disorders and symptomatology in a probability sample of the adult Puerto Rican island population. Their finding that gender differences in depressive symptomatology are greater for island Puerto Ricans than for U.S. mainland populations is interpreted as reflecting the more patriarchial social context of Puerto Rican society.

Comas-Diaz (1987) focuses on feminist therapy with mainland Puerto Rican women, examining the experience of cross-cultural translocation, the colonial background of Puerto Rico, and the complexity of identity development for contemporary mainland Puertorriqueñas. She points out that there has been an increase in feminist awareness and questioning of gender roles among women in Latin America. Feminism, with its political and social values that support the equalization of power between the sexes, is seen as relevant to all women, although acquiring a different form in the specific Hispanic reality, and depending on the social and cultural context. She expands Canino's description of the patriarchial nature of Puerto Rican society, discussing implications of concepts such as espiritismo, marianismo and hembrismo for empowerment of Puerto Rican women. She discusses the implications of the process of transculturation for the self-identity of mainland Puerto Rican women, and discusses the application of feminist therapy to this population. Her approach complements and enriches the epidemiological analyis of Canino and her colleagues.

Acculturation and Migration/Immigration

Acculturation, the process by which the immigrant's attitudes and behaviors change toward those of the dominant cultural group as a result of exposure to the new cultural system (Rogler et. al., 1987), has been identified both as a source of stress as well as a factor affecting access and appropriateness of treatment in Hispanic populations (Canino, 1982; Rogler et al., 1987). Like the Puerto Rican women discussed by Canino et al. (1987) and Comas-Diaz (1987), Mexican-American women report more depressive symptoms than Mexican-American men, even after controlling for effects of age, education, and income (Roberts & Roberts, 1982). Salgado de Snyder examines factors associated with acculturative stress and depressive symptomatology among married Mexican immigrant women, finding them at risk for psychological problems due to discrimination, sex role conflicts, and concern about starting a family in the U.S. She underscores the need to study patterns of psychosocial adjustment among immigrant Hispanic women.

Espin's clinical approach complements the survey research conducted by Salgado de Snyder (1987). She examines the psychological implications of the immigration process, addressing issues that immigrant Hispanic women frequently present in therapy related to gender roles, acculturation, language, and loss and grief. Her clinical observations point to the need for research on therapy with bilingual patients. She suggests that the combined use of English and Spanish in therapy can facilitate the emergence and discussion of taboo topics, and can be an important tool for reclaiming parts of the self lost in the process of acculturation. Most importantly, she points out that these reactions to migration are *normal* consequences of a disturbing process and not signs of individual pathology. After reading her article, it is clear that all therapists working with immigrant Latinas need to understand the effects of the migration process.

Employment and Mental Health

Most discussions of mental health of Hispanic populations have been based on a picture of a ". . . person pressured and harassed by problems of poverty, slum life, and lack of acculturation into American society" (Rogler et al., 1987, p. 567). While we have described how Hispanic women, with the exception of Cubans, are likely to have lower incomes, less education, and higher fertility than Anglo women, 13% of Hispanic women have a professional or managerial status (Bureau of the Census, 1985b). Amaro et al. (1987) examine family and work predictors of psychological well-being among this select group. Their findings emphasize the need to conduct separate analyses for Hispanic women of diverse ethnic groups. They underscore the importance of examining characteristics of both home and work environments if a complete picture of factors influencing employed women's mental health is to be attained. Further research is needed to examine how employment and family conditions affect the mental health of Hispanic women in professional and nonprofessional occupations. Since a disproportionate number of Hispanic women are employed in services, clerical, and operative occupational categories, research on women in those occupations is particularly important.

The picture of the active, effective, professional Hispanic women that emerges from their research rebuts the cultural stereotypes that depict Hispanic women as solely deriving their identity and personal life satisfaction from the roles of mother and wife, and communicates instead the reality of the multiple sources of personal and life satisfaction for these women.

It is noteworthy that experience of discrimination was associated with psychological distress symptomatology in work by Salgado de Snyder with immigrant women, as well as by Amaro, Russo, and Johnson with high income, highly-educated professional women. It appears that addressing issues of discrimination has potential mental health benefits for a diverse group of Hispanic women.

A LOOK TO THE FUTURE

As Amaro et al. (1987) observe, there is a growing body of research on Hispanic women, but most previous studies have focused on Hispanic women's functioning in traditional roles. Even the work on the mental health of Hispanic women has focused on conflicts engendered by traditional Hispanic culture. It is our goal that the work presented here will help to stimulate research that will empower Hispanic women, change the nature of treatment and service delivery, and transform education and training programs so that they will truly encompass human diversity. The selected bibliography by Amaro, Russo, and Pares-Avila (1987) is designed to facilitate such research in addition to enhancing efforts to integrate scholarship on women into the curriculum.

In conclusion, it is increasingly recognized that gender plays a critical role in the etiology, diagnosis, treatment, and prevention of mental disorder and in the promotion of mental health and well-being. If the nature of that role is to be understood for all women, research design and analysis must advance beyond the use of sex as a correlated or predictor variable. As Vazquez-Nuttall et al. (1987) demonstrate, the concepts of masculinity and femininity may take on different meanings in different cultural traditions. Thus, gender must be conceptualized as a dynamic construct that *itself varies across ethnic groups and social classes* and works in complex interaction with other psychological and social factors (Russo, 1987). We believe that work in the psychology of Hispanic women thus can inform all gender research.

NOTE

1 The term "Hispanic" refers to persons of Spanish origin, including Mexican, Puerto Rican, Cuban, Central or South American, and Spanish. Hispanics may be of any race. The term "Anglo" refers to Whites not of Hispanic origin.

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— CHAPTER TEN

Cubans

GUILLERMO BERNAL AND MANUEL GUTIERREZ

INTRODUCTION

The role of ethnicity or culture is a central consideration in providing health and mental health treatment to minority populations. Clinicians need to be equipped with basic information about the group in question, as it is critical to define what may be general and what may be specific to a particular ethnic group.

Three questions are important to consider when examining the role of ethnicity and culture in clinical work:

1. What are the effects of culture on individuals and families?
2. How does one learn about and use culture in a therapeutic way?
3. How do the effects of culture and social class interact?

A problem in defining any cultural group is that, by necessity, any description freezes the culture in time. While culture may be defined as the social transmission of ideas, attitudes, and traits that condition social

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behavior (Bernal & Alvarez, 1983), it is difficult to describe the fluid and dynamic nature of the transmission of these ideas and behaviors. Indeed, the risk involved in static descriptions is of supporting cultural stereotypes and prejudicial views. Culture must be understood as a *process* linked to time, conditioned by the evolving social and economic context of the ethnic group in question.

However, even when these caveats are taken into consideration, there is no guarantee that the knowledge of culture would enable a therapist to become more effective in dealing with an individual or a family (Montalvo & Gutierrez, 1983). For example, within a family systems model, therapists who overstress the role of culture can be creatively assimilated by their clients. Montalvo and Gutierrez (1983) point out that a therapist should focus on fundamentals—what is basic to families—rather than on idiosyncratic cultural dimensions that may tend to make the family alien to the therapist. A helpful dimension is to look at the interinstitutional relationship between the family and the host culture, and to look at how successful or unsuccessful the family is in traversing these often complex relationships. Often, failure in these interinstitutional relations gives rise to dysfunctional patterns or pathology.

The notion that a bicultural socialization occurs when there is some successful integration from a minority to a majority culture was supported by de Anda (1984), who emphasized the bicultural socialization role of social welfare workers. In searching for a model that would be helpful for therapists working with the family, de Hoyos, de Hoyos, and Anderson (1986) identify two traditional approaches to the understanding of minority problems in social work: cultural dissonance and institutional racism. The cultural dissonance approach focuses on the problems that emerge because of cultural differences, while the institutional racism approach views problems as the result of discrimination in social structures. The authors describe a three-stage model that goes beyond cultural dissonance and institutional racism explanations, progressing from individual intervention to interactional intervention to sociocultural intervention. The sociocultural approach looks at the interaction of the individual with "the impersonal institutions of society—the economy, the government, religion, and education" (p. 62), allowing for more comprehensive interventions.

The purpose of this chapter is to describe a minority population—Cuban-Americans—by pointing out some characteristics that may be more predominant among this minority than among other minority groups in the United States. Specifically, we are referring to demographic, political, and migratory differences. Later on we will discuss some of the mental health problems that this group faces, though it is important to note that, when dealing with clinical syndromes, we do not consider that there are any typically Cuban syndromes. In fact, we believe that any individual or family from any other minority group could present the same clinical pictures found among Cuban-Americans. The notion of culture-specific syndromes is not a particularly helpful one for clinicians. Rather, we prefer to examine the dynamics and areas of friction between two cultures, and to study interfaces that provide valuable diagnostic clues as to what is going on with a particular individual or family.

CUBANS IN THE UNITED STATES

Cubans represent the third largest Hispanic group in the United States. The U.S. Census Bureau reported the Cuban population to be 803,226 in 1980. However, this figure did not include the almost 125,000 Cubans who immigrated to the United States from the port of Mariel during the later part of 1980. Thus the Cuban population in the United States rapidly increased by 15 percent in a matter of months and exceeded the figure of over 1 million inhabitants (Santiestevan & Associates, 1984).

Cubans have established themselves throughout major metropolitan areas in North America. Miami is clearly the central geographic location, with a high concentration of Cubans. Seventy percent of all Hispanics (580,995) in Dade County, Florida, are Cuban or of Cuban descent. The other key geographical areas with a significant Cuban presence are New Jersey and New York. A sizable though smaller proportion of Cubans are also found in Los Angeles, Chicago, and other major American cities.

In comparison to other Latinos in the United States, Cubans have been considered a model minority group as measured by indices such as income and educational level. Bernal (1982) has noted that the so-called "success" story of Cubans must be tempered by the unusual demographic characteristics of its migratory waves and the response these groups received from the United States.

Briefly, first-wave Cubans migrated between 1959 and 1965. Pooling census data with registries at the Miami Cuban Refugee Center, Jorge and Moncarz (1980) estimated that 183,426 Cubans arrived during this wave. This group was disproportionately composed of Whites, upper-class, upper-middle-class, and middle-class Cubans who had educational, business, and financial resources and shared a set of values and beliefs in common with the dominant U.S. culture. First-wave Cuban immigrants received massive financial, educational, and training support from the federal government (Bernal & Estrada, 1985; Cortes, 1980a; Cortes, 1980b; Pedraza-Bailey, 1985; Prohias & Casal, 1980). The Cuban Refugee Program, the Cuban Student Loan Program, and the Small Business Administration Program are but a few of the resources and opportunities that the federal government made available to Cubans. It is no small wonder that Cubans fare comparatively better than Mexican-Americans, Puerto Ricans, and other Hispanics (of Central and South American origin) in population indices of education, income, and occupational levels (Santiestevan & Associates, 1984).

The second major wave of Cubans began in 1965 and ended in 1973. About 264,300 persons entered the United States at this time (Jorge & Moncarz, 1980). The opening of the port of Camarioca to all who wished to leave Cuba was an interesting historical precedent to the Mariel incident. About 5000 Cubans left in boats to Miami prior to the immigration agreement that resulted in the airlift from Havana to Miami. Cubans leaving at this time were composed of middle-class, lower-middle-class, and working-class persons. This group resembled more the traditional immigrant to the United States but again was not representative of the Cuban population as a whole, since this wave was heavily represented by Whites, adults, and women.

During the summer of 1980, a third wave of Cuban immigration began. By 1982, the influx of Cubans from Mariel was reduced to a trickle but the Cuban-American population had grown by 15 percent. In contrast to the first two waves, the wave of Mariel immigrants reflected the Cuban population as a whole in terms of race, occupational levels, and education. This wave was mostly composed of working-class persons who looked to the United States for economic opportunities. A second, smaller group was composed of "antisocial" persons who lived on the fringes of Cuban society (Bernal, 1982).

Understanding the nature of the Cuban migration is critical in order to appreciate the differences between Cuban-Americans, Mexican-Americans, Puerto Ricans, and other Latinos as well as the differences in the socioeconomic structures of these groups. The Cuban migration as a whole is a "political" phenomenon, not solely because the motivating factor to migrate was either economic or political (Fagen, Brody, & O'Leary, 1968). As already described, the different immigration waves from Cuba were made up of persons wishing to leave Cuba for multiple reasons (economic, political, or both). What is important in understanding the differences between Latino minority groups is the sociopolitical relationship between the two countries and the response to the migration of the host culture. For example, the social and political relationship between the United States and either Puerto Rico or Mexico has been such that neither group warranted a "political" response by the host country. By comparison, the Cuban immigration served a variety of U.S. political interests (e.g., destabilizing Cuba, pointing to the dangers of socialism, etc.).

The view of the Cuban immigration as a political phenomenon is further supported by the socioeconomic structure of the Cuban-American society that developed in the United States. We shall now turn our attention to describing further the demographic profile and examining differences among Cuban-Americans as a means to appreciate the sociocultural heterogeneity of this group. As will become clear, these distinctions are necessary as it is impossible to speak of one single Cuban-American culture. When examining culture and ethnicity, it is necessary to frame the discussion in terms of the subculture of specific socioeconomic groups.

Social and Economic Differences Among Cuban-Americans

One of the unique aspects of the Cuban experience is a politically linked migration. This meant that substantial sectors of upper-class, upper-middle-class, and middle-class Cubans left, bringing with them educational and occupational resources; some already had financial resources in the United States. While many Cubans, as with most other immigrants to the United States, experienced a significant downward socioeconomic move as a result of the migration (Jorge & Moncarz, 1980), substantial sectors of the Cuban community developed retail and manufacturing enterprises. Indeed, as early as 1967, Jorge and Moncarz (1980) found 919 Cuban-owned enterprises in Miami. This number had almost doubled by 1969 and had increased to 8000 by 1976. Thus in a relatively brief period of time the beginning of an economic enclave in the Cuban community was developed, and with it emerged a social structure resembling that of pre-1959 Cuba. (Because of the limits of space, we have restricted our discussion to Cubans in the United States. It should be noted that there are large Cuban communities in Puerto Rico and other parts of Latin America. For a discussion of Cubans in Puerto Rico, the reader may refer to the work conducted by Perez-Cruz [1984] and Esteve [1984].)

While the migration weakened some of the class barriers of pre-1959 Cuba, what is evident in the Miami Cuban enclave is a reproduction of that very same class structure, the exception being the nouveau riche, who rapidly rose in the socioeconomic ladder during the social vacuum of the early 1960s. The resettled Cuban aristocracy together with the nouveau riche make up the Cuban elite. Efforts to preserve the status system and values of prerevolutionary Cuba are pervasive. For example, the aristocratic clubs that were prevalent in Cuba before the revolution are now also prevalent in Miami. The five main society clubs have joined under one umbrella organization, now called the Big Five Club. Membership in the club is virtually restricted to people who used to belong to similar clubs in Cuba or their family members; this is one way to re-create the previous social life in Cuba where these families can maintain a myth of aristocracy and high society.

The social structure of the Cuban community has been examined by a number of authors (Jorge & Moncarz, 1980; Portes & Bach, 1985; Prohias & Casal, 1980; Santiestevan and Associates, 1984; Valdez-Paz & Hernandez, 1984). Here we will attempt to integrate the work of Valdez-Paz and Hernandez (1984), based on a study of the U.S. Census, with other analyses of the Cuban community.

Five socioeconomic groups may be identified in the Cuban community (Valdez-Paz & Hernandez, 1984). First is a Cuban-American elite that originated during the first wave of immigration. This group consists of the Cuban aristocracy and the displaced bourgeoisie, who had links to U.S. capital and contacts to U.S. business prior to 1959. Together with the nouveau riche they make up about 1 percent of the economic force, consisting of large- and medium-sized business entrepreneurs, and may number as many as 25,000 families.

The second is an upper-middle-class sector composed of professionals, owners of small businesses, retail and service shops, and so on (Valdez-Paz & Hernandez, 1984). This group is similar to the petit bourgeoisie who left Cuba but incorporates a number of individuals who established small businesses aimed at providing services to the Cuban-American community that have grown substantially since the late 1960s and early 1970s (Jorge & Moncarz, 1980). This upper-middle-class group represents about 18 percent of the total work force.

The middle class is the third socioeconomic group. This is a heterogeneous sector of the population made up of salaried individuals such as professionals, technicians, administrators, managers, and so on, who are not owners of capital. This group includes persons from the first and second wave of immigration that were largely from the middle and working classes. Also, second-generation Cuban-Americans, Cubans who migrated with their parents when they were approximately 5 to 15 years of age, and persons from the displaced Cuban elite are found among this third group. According to Valdez-Paz and Hernandez (1984), the middle class is about 21 percent of the work force.

The fourth and largest sector in the Cuban community is the working class. This is a more homogeneous group, made up of salaried workers not connected to the means of production who work in the production of materials and the provision of services. Salaried office workers are also part of this group. Valdez-Paz and Hernandez (1984) estimate that this group represents about 60 percent of the work force.

The last group to consider is an antisocial sector of society. Two subgroups are identified in this category. One is from the first wave of immigration and represents elements of the Cuban population who had links to organized crime in the United States. Arguelles (1982) has noted that the economic roots of Cuban Miami are found in the endeavors of U.S. organized crime syndicates that prior to 1959 (the forties and fifties) developed a network of tourism, gambling, and drug trafficking. The other antisocial subgroup is a subset of the most recent immigration wave. A portion of the Mariel entrants were marginal to Cuba's social, political, and economic process; some had been incarcerated and left Cuba either voluntarily or with the encouragement of the government.

The sociocultural implications of this stratification are significant in that at one level the economic enclaves that developed in Miami and Union City, New Jersey, have facilitated the assimilation of Cubans (Portes & Bach, 1985). Also, in cities where there is an economic enclave, Cubans have been able to develop some degree of political power.

While Cubans have identified with other Hispanics on some issues (e.g., on bilingual education), for the most part they have become a highly conservative group. For example, while a majority of Puerto Ricans and Mexican-Americans voted for the Democratic Party candidates, in the 1976 and 1980 presidential elections a majority of Cubans voted for the Republican Party candidates (Santiestevan & Associates, 1984). Similar voting patterns were evident in the 1984 election. The attraction to the Republican Party reflects their conservatism in international affairs.

These social processes are important to consider because the Cuban cultural experience is significantly influenced by socioeconomic status. The clinician will need to understand the Cuban experience as it exists for the Cuban elite, the upper middle class, the middle class, the working class, and the antisocial classes. Now we shall turn our attention to some of the psychological aspects of the Cuban experience in the United States.

The Cuban Experience in the United States

Rumbaut and Rumbaut (1976) were among the first mental health clinicians to write about the Cuban experience. These authors, writing about the first two waves of immigrants, note that the ordeal of expatriation has produced anguish, conflicts about the uprootedness, and traumatic loss. The buffers to these losses and conflicts are the relatively high occupational and educational levels coupled with informal grass-roots social and community supports, as well as organized support from local, state, and federal government.

The psychological aspects of the Cuban exile experience can present mental health conflicts related to loyalty binds (between country of origin and host country), culture shock, initial anxiety, and depression, particularly during the early stages of the migration (Rumbaut & Rumbaut, 1976). The image of Janus—the Roman god of beginnings able to look in opposite directions simultaneously with his two faces—captures part of the struggle facing the Cuban arrivals. Facing the past can be a painful experience as issues of cultural, familial, and economic loss, abandonment, and death must be dealt with. Facing the future means building a new life, looking to meet new challenges, and struggling in a new and different cultural context (Rumbaut & Rumbaut, 1976). The dialectical resolution between these two sides captures part of the struggle that either may be constructively resolved or may persist for years, affecting the next generation of Cuban-Americans.

For a major subgroup of Cubans—the elite and part of the nouveau riche—Cuban culture in the United States is the image of Cuba as it existed in 1959. This is a subgroup that has not progressed much beyond these values, has not assimilated much from the U.S. norms, and rejects changes that have taken place in Cuban society and Cuban culture in the island. Gozalez-Reigosa (1984) refers to these individuals as representatives of the frozen culture.

A second and larger group developed what may be termed the Little Havana culture as part of the Miami Cuban experience. This is a Cuban-American group not frozen in time, molded by the life experiences in Cuba and in the United States but not accepting the cultural manifestations from the island. Their primary point of reference is Miami.

The third group is mostly composed of young people who were born in the United States or have had most of their life experiences in the United States and have for the most part totally acculturated to mainstream North American society while rejecting traditional Cuban values.

A fourth and smaller group has demonstrated an interest in reestablishing links with their Cuban roots and with the cultural manifestations of present-day Cuba. The dialogue that started in 1978 between Cuba and the Cuban community in the United States resulted in opening up travel to Cuba for the first time in many years. Families were allowed visits, and many Cubans were able to reconnect with their country and culture or origin. The dialogue was a key event for the Cuban exile community.

Azicri (1982) has described the experience of the Cuban community in the United States as a social and political process involving two phases. The first phase extends from 1959 to 1978. This period of adaptation and assimilation was described as de-Cubanization, given the disconnectedness to the culture of origin, the attempts to reconstruct a pre-1959 Cuba in the United States, and the uncritical acceptance of U.S. values and norms. With the dialogue of 1978 and the Mariel immigration of 1980, the Cuban community went through a process of re-Cubanization. Cubans in exile were revitalized by the contact with Cuba, as well as by the energy and vigor of a new immigrant group. De-Cubanization was halted, and with it a new opportunity emerged for Cubans in the United States, that is, establishing links with their cultural roots and contemporary Cuba.

ETHNOSOCIOCULTURAL ISSUES

A number of clinicans and researchers have written about the cultural values that may facilitate the clinical work with Cubans (Bernal, 1982; Queralt, 1984; Rumbaut & Rumbaut, 1976; Szapocznik, Kurtines, & Hanna, 1978). Like a number of other Hispanics in the United States, Cubans share many Latino and African cultural patterns (Bustamante & Santa Cruz, 1975; Ortiz, 1973) found among Caribbean and Central and South American peoples. Principally, these areas of commonality are traditional values toward the family, community and other social supports, religion, and language. Below, we provide a thumbnail sketch of Cuban cultural traits. We begin with characteristics Cubans share with other Latinos, and we will attempt to point out some of the factors that distinguish Cubans from other Latinos. Clearly, the cultural heterogeneity among Cubans is extensive, and variations are found within different socioeconomic groups.

La Familia

The importance and central role of the family is pervasive among Cubans in the United States. *Familismo*, the cultural attitudes and values toward the family as central in the life of the individual, is the basis of the Cuban family structure (Bernal, 1982; Queralt, 1984). In general, the Cuban family may be characterized by powerful bonds of loyalty, commitment, and unity that include both nuclear and extended family members.

The traditional view of the family is based on a hierarchy where publicly the male is at the top and expected to be the provider. *Respeto* is a means of enforcing authority from the wife and children. Marital conflicts may arise when the wife works, thus tilting the balance of power in the marriage. As the children begin to adopt U.S. norms and values, intergenerational conflicts may also develop. In a study of Cuban family relations, Richmond (1980) found that egalitarian as compared to traditional family values were related to length of residence in the United States and greater association with North Americans. Cuban women working outside the home also insisted on egalitarian values and ideals.

Acculturation is a significant factor affecting family life. Intergenerational and marital conflicts have been documented (Bernal, 1982; Szapocznik & Truss, 1978). These conflicts often arise from the collision between the values of one generation and those of another. While the nature of Cuban marriages and family life largely depends on social class, degree of acculturation, and migration stage, the legacy of Hispanic cultural family values remain strong. For example, notions of *machismo*, female marital fidelity, and virginity are apparent in modern-day Cuban relationships. Similarly, childrearing patterns emphasize the protection of girls to ensure their innocence.

The use of *chaperonas* in courtship is still common with many families as a means of protecting their adolescent girls (Bernal, 1982).

Language and Cuban Values

Language is probably one of the most important aspects of Cuban family life (Bernal, 1982). Language is the carrier of the culture. The cutoff from the culture of origin and the negative political connotations of reconnecting with Cuba have pushed a younger generation of Cubans into a position of over-assimilation. As a result, "Spanglish" is probably spoken most in Cuban-American homes (Queralt, 1984). The older generation speaks Spanish and the younger generation speaks a hybrid of English and Spanish or only English. Nevertheless, a recent study (Díaz, 1980) of the Cuban community found that most Cubans surveyed report speaking Spanish at home. Clearly, a Spanish-speaking capability plays a major role in the delivery of health and social services. This is particularly the case if the clinician is to work with the elderly. As Bernal (1982) has noted, an important aspect of therapy may be to facilitate a recapturing of the language if it has been lost by the younger generation.

Cuban values have been examined by a number of clinicians and investigators (Bernal, 1982; Queralt, 1984; Marin, VanOss-Marin, Sabogal, Otero-Sabogal, & Perez-Stable, 1986; Szapocznik, Scopetta, De los Angeles, & Kurtines, 1978). In general, there is agreement that Cubans are oriented more toward persons and people than to ideas or abstractions in relationships. *Personalismo* represents a dignified personal approach to social situations and a distaste for impersonal aspects of situations (Queralt, 1984).

A recent large scale study (Marin et al., 1986) of acculturation and subcultural differences among Hispanics found more similarities than differences between Cubans, Mexicans, and Central Americans in the United States. However, Cuban-Americans scored closer to the non-Hispanic direction than Mexican-Americans and Central Americans on the value of allocentrism–collectivism. Cubans tended to endorse individualistic responses in problem-solving situations significantly more often than the other two Hispanic groups.

Bernal (1982) has noted that *choteo*, a form of humor aimed at ridiculing everyone, including oneself, is common to interpersonal relations among Cubans. Ortiz (1973) considers *choteo* a typical Cuban phenomenon that often involves exaggerating things out of proportion. *Choteo* is an important mechanism to reduce tension in difficult situations and to reduce interpersonal distance. When *choteo* is combined with *tuteo*—the informal use of *usted* (you), familiarity is established in interpersonal relations and distance is diminished further.

Cubans are oriented toward lineality and hierarchy in family relations. Values of action, doing, and present orientations are preferred (Bernal, 1982; Szapocznick, Scopetta, De los Angeles, & Kurtines, 1978). Thus treatment models that focus on the present are active, aim to solve problems, and involve the family are more likely to be successful.

Support Systems

Through religious, social, health, and political organizations, systems of support were quickly established within the Cuban community. One of the first organized systems of support was the Cuban Refugee Center. Initially, the center provided basic support in terms of food, clothing, and shelter. Additionally, financial aid, health care, and later assistance in finding work and relocating outside South Florida and housing were made available. A complete discussion of the Cuban Refugee Center and its role and functions may be found in Prohias and Casal (1980).

The church is another instrument of social support. While Catholicism is the religious preference of most Cubans, the number of Cuban Catholics appears to have decreased in the United States (Rogg & Cooney, 1980), perhaps as a reflection of their becoming more integrated into mainstream North American life. Nevertheless, the church remains a powerful base of support for families. The religious community may be an important resource in the therapeutic enterprise, particularly for the elderly Cuban populations.

Folk-healing traditions that integrate African beliefs with Catholicism are common within some sectors of the Cuban community. Indeed, *botánicas* are becoming increasingly visible in most Latino neighborhoods. A *botánica* is a store where special herbs, potions, and candles may be purchased. Some of the *botánicas* are operated by *santeros* or *espiritistas* (mediums). *Santeros* are individuals who initiate others in the religion or faith-healing system of *santería*, an Afro-Cuban religion that combines the beliefs of the African (Yoruba) *Orichas* with the Catholic saints. According to Sandoval (1977) a *santero* is a priest dedicated to the cult of the *Orichas* who also functions as a healer, diviner, and director of rituals. *Santeros* believe that diseases are due to natural and supernatural causes. While a survey of the health and mental health needs (Díaz, 1980) among Cubans found that the majority of those surveyed do not use *santeros* as a primary service of health care, one out of every four respondents indicated he or she would use *santeros*, if needed. In contrast to *santería*, *espiritismo* is a faith-healing system that predominates in Puerto Rico but is found in the Oriente region of Cuba. Spiritist practice is based on a medium as a healer who exorcises the spirits causing the illness (Bernal, 1982). With some individuals, mobilizing the folk-healing system of support can be an important leverage in therapeutic change.

Health, social, and political organizations constitute another important source of support. For example, private clinics are preferred in Miami by low- and moderate-income Cubans (Diaz, 1980). These clinics follow a tradition established in Cuba during the forties and fifties where individuals and families became members of private clinics and were thus entitled to received a variety of health services. With the trend toward privatization in the United States, these *clinicas* are becoming increasingly popular in Miami. Social and political organizations, while diverse and heterogeneous, provide another source of support and cohesion for the community.

CLINICAL ISSUES

Attitudes Toward Mental Health

Prior to the Cuban revolution in 1959, most Cubans perceived mental health services as the treatment of "crazy" people. A strong social stigma prevented seeking psychotherapy. Psychology was an emerging profession with few qualified clinical psychologists, most of whom had trained in the United States (Bernal, 1985; Garcia-Averasturi, 1980). Psychiatry was associated with the infamous *Mazorra* hospital in La Habana, a custodial institution for chronic mental patients lacking the most basic standards of hygiene and nutrition (Camayd-Freixas & Uriarte, 1980). Thus changes in attitudes toward mental health—for the pre-Mariel Cuban immigrants—reflect the influence of prevailing attitudes and behaviors in the host culture. Two survey studies to be described provide the most detailed information on this specific issue.

In a survey of 300 Cuban adults in West New York, New Jersey, Rogg and Cooney (1980) explored attitudes and behaviors related to mental health. When asked to whom they would turn for help if they or someone in their families developed serious nervous or emotional problems, 46 percent would go to their family doctor as a first choice, with another 28 percent seeking help from friends or relatives, and 13 percent from a therapist in private practice. Interestingly, only 2 percent of the sample stated that they would go to a mental health clinic as a first choice. When asked, more specifically, whether they would consider consulting a mental health professional if they had a problem, 84 percent indicated that they would definitely consider it and another 12 percent would probably consider it. When asked the kind of mental health professional they would prefer to use, 35 percent would go to a psychiatrist in private practice, 31 percent to whomever the

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family doctor recommended, and 13 percent to a psychologist in private practice. Only 11 percent would seek help from a professional in an agency or clinic. These findings show a definite preference for professionals in private practice over those found in a clinic. Since West New York does not have the developed clinic network that Miami has (Diaz, 1980), these findings cannot be generalized to the whole Cuban population in the United States. Nevertheless, it is important to note that the respondents in the sample showed a strong preference for medically trained professionals—family doctors and psychiatrists—for dealing with mental health problems. In addition, psychiatrists were perceived as being better trained than either psychologists or social workers.

Most of the respondents in this study, 71 percent did not feel that people seeking mental health treatment were different from themselves, and 74 percent felt that people with nervous or emotional problems can get well. However, when asked if people who are "crazy" can get well, only 20 percent responded unequivocally that they could, with another 58 percent responding that "some can, some can't." In terms of actual experiences with mental health problems, 21 percent of the respondents indicated that they had experienced nervous or emotional problems since coming to live in West New York. Of these, 97 percent had sought help. Most of those seeking help had gone to a family doctor (66 percent), while a sizable group had been to a psychiatrist in private practice (27 percent). These results validate attitudes found in the entire sample. The study, unfortunately, did not report on the social characteristics of the subsample that sought treatment or the symptoms or complaints exhibited by this group.

A second study, conducted in Miami during 1980 and 1981, examined the attitudes of a nonclinical sample of 240 Cubans toward seeking psychotherapy (Casero, 1982). In this sample, 16.7 percent reported having seen a psychiatrist or a psychologist for mental health problems. While this rate is lower than in the West New York study (21 percent), it does not include respondents who may have sought help from a family doctor—a significant majority in the West New York study. Results of this study showed that sex, age, prior therapeutic experience, and Cuban ethnic identity were the best predictors of attitude toward seeking psychotherapy. Respondents who exhibited more positive attitudes toward psychotherapy were more likely to be female, young, to have had a prior therapeutic experience, and to have a higher level of acculturation.

These findings, along with the authors' clinical experiences, point to general tendencies that would, of course, vary from case to case. First, there appears to be a preference for a formal therapist-patient relationship on the part of the patient. Educational level, knowledge, and reputation of the therapist are greatly valued. As previously noted, there is a strong tendency to seek help from medical doctors and psychiatrists, though this may not be as pronounced in communities where other mental health professionals become known as effective practitioners.

Similarly, attitudes toward medications vary a great deal. To our knowledge little if any research has been conducted on the attitudes of Cuban-Americans toward receiving and complying with medical treatments for psychosocial disorders. Clinical experience shows that these attitudes range widely and seem to be a function of social class, level of education, and acculturation.

Cuban and other Hispanic therapists are likely to be sought because of language and cultural considerations. Not surprisingly, women exhibit less reticence than men in entering psychotherapy. This reflects traditional family values shared by other Hispanic and non-Hispanic groups whereby men would perceive their authority in the home undermined if they were to acknowledge personal difficulties requiring treatment. These traditional values also extend to child-centered problems, which may be seen by fathers as the responsibility of their wives and not requiring their involvement in therapy. These attitudes would be less likely to be found among younger, more acculturated Cubans.

As previously noted, Szapocznik, Scopetta, De los Angeles, and Kurtines (1978) have pointed to the prevailing present-time orientation among Cubans, which would suggest an expectation for the quick resolution of problems. However, since time orientation may be affected by, among other variables, social class status, education, and degree of acculturation, it is not helpful to assume specific treatment expectations on the part of the patient. It may be far more helpful to inquire as to the patient's expectations at the outset.

CLINICAL PRACTICE

Assessment: Symptomatic and Adaptive Behavior

Several authors have noted that, as a group, Cubans have experienced a loss of occupational status after migration (Casal & Hernandez, 1975; Hernandez, 1974; Rogg, 1974). While some working-class Cubans have been able to improve their socioeconomic conditions in the United States, it has been far more common for the elite, upper-middle-class, and middle-class Cubans to have experienced a downward occupational mobility at the time of arrival. Reports on occupational gains over time are mixed. In West New York, Rogg and Cooney (1980) found that Cubans had experienced notable upward mobility between 1968 and 1979. However, in a longitudinal study of Miami-based Cubans, Portes and Bach (1985) report that in a 6-year period, between 1973 and 1979, Cuban refugees "still had not reached the level of their original occupations in Cuba or their aspirations for life in the United States" (p. 196).

Another factor to consider is acculturation stress, typical of any migratory group. Intergenerational conflicts are often the result of a faster acculturation rate among second-generation Cubans than among their parents (Rogg, 1974; Szapocznik & Kurtines, 1980; Szapocznik, Scopetta, & King, 1978; Szapocznik & Truss, 1978). Closely tied in to this source of stress are the changes that have occurred in the family structure, as a very high proportion of Cuban women have been incorporated into the U.S. labor force (Casal & Hernandez, 1975; Prieto, 1984), thereby influencing traditional male-female roles.

While many stresses and disruptions are inevitable as a result of a migration, this is often a time of great adaptation and supportive behavior. In the 1968 study of the Cuban community in West New York, Rogg (1974) found no severe adjustment problems. The author emphasized the strong manifestations of ethnic identity and family and social supports in that community, which mitigated against problems such as dropping out of school, juvenile delinquency, or family disorganization. In a subsequent study of 300 adult Cubans in West New York, Rogg and Cooney (1980) found that reporting nervous or emotional problems was not associated with social characteristics such as education, age at arrival, years in the United States, or sex; it was only associated with low frequency of church attendance. The authors interpreted this finding as reflecting a low index of community integration for those individuals, as measured by the lack of organizational (church) involvement.

Special Mental Health Problems

As the early Cuban immigrants of the sixties and seventies have become more settled and assimilated into the North American mainstream, problems affecting the population at large also appear to be affecting the Cuban population. A large survey (Díaz, 1980) conducted by the Cuban National Planning Council in five cities (Miami; Union City–West New York, New Jersey; New York City; Chicago; Los Angeles) just prior to the Mariel exodus in 1980 identified the following special problems: a recent increase in dropout rate in Miami public schools; a high incidence of hypertension among adolescents in Miami public schools; a large number of elderly individuals who underutilize nursing homes; and an increased divorce rate. While these were not directly surveyed, the author also comments on the rising incidence of drug addiction and alcoholism, as well as the indication that "mental health problems are salient among the general health concerns of the Cuban population in the U.S." (p. 29).

Ladner, Page, and Lee (1975) have reported on the epidemic abuse of sedatives and tranquilizers, and frequent overdose of these drugs by Cuban middle-aged women. In a study of 286 patients at the Spanish Family Guidance Clinic, Ladner (1976) found that the population at risk for drug abuse consisted of divorced males and widowed females; there were no significant sex or age differences in drug abuse pathology scores. Alcoholism pathology scores were significantly related to age (older patients) and sex (males). Married males and widowed females were more at risk for alcoholism than other groups. The drug of choice for women in this clinic population was tranquilizers, while the drugs of choice for men were illicit sedatives, narcotics, and marijuana. Page (1980), in a study of drug use among Cuban youth in Miami, pointed to the disavowal of traditional Cuban values and adoption of the youth subculture of the United States as an important factor associated with drug use. Another factor was the desire for a positive experience or a recreational high.

The Mariel migration has presented special problems due to a multiplicity of factors. First of all, the composition of this migration was very different than that of earlier waves. The 125,000 Cubans who came via Mariel were mostly male, young, and working class (Bienia, Van Der Decker, & Bienia, 1982). Second, they arrived in the United States at a time of high unemployment and uncertain economic conditions. The U.S. government did not provide the special programs for this wave of migration that were provided for earlier waves. Thus this group faced harsher economic and social conditions upon arrival. Resentment from the earlier immigrants became widespread initially, as the Mariel immigrants were labeled criminals and mental patients by politically motivated media reports. The controversy raged as to whether the Mariel migration was the result of Castro's emptying Cuba's prisons and psychiatric institutions. In fact, Bienia and colleagues (1982) report that, of the total 125,000 refugees, only "about 3% were recognized as having serious psychological, social, or criminal problems," although there may have been others "whose problems were not detected in the screening centers" (p. 596). Third, placement in relocation centers, awaiting processing, was often a very traumatic experience for the immigrants, who had expected to be received with "open heart and open arms"—as President Carter asserted (*Time*, 1980)—and instead were confined to military installations. While as of yet there are no available statistics on the incidence of mental health problems among the Mariel immigrants, consideration of the factors just mentioned would suggest that this group is likely to experience more stresses and adjustment problems than earlier waves of Cuban immigrants.

Treatment

Although diverse treatment modalities have been used with Cubans (e.g., Bernal, 1982; Franklin & Kaufman, 1982; Hynes & Werbin, 1977; Klovekorn, Madera, & Nardone, 1974; Lefley, 1975; Normand, Iglesias, & Payn, 1974; Rubinstein, 1976; Tylin, 1982), little systematic treatment outcome research exists with Cuban-Americans. To date no clinical trials have been conducted that examine the differential rates of effectiveness for either different treatment modalities (psychosocial vs. pharmacotherapy, or individual vs. family or group) or theoretical approaches (behavioral, psychodynamic, etc.) for specific syndromes with this population. Indeed, treatment outcome studies are extremely difficult to conduct.

The Spanish Family Guidance Clinic in Miami deserves recognition for carrying out the only existing treatment outcome research with Cuban-Americans. Szapocznik and his associates conducted several studies to identify the drug abuse and mental health needs of Latinos and to demonstrate the effectiveness of culturally appropriate treatments. In a preliminary study, reported earlier, the structure of Cuban values was examined (Szapozcnik, Scopetta, De los Angeles, & Kurtines, 1978). Based on these early findings, they developed an ecological, structural family therapy treatment model in an effort to match treatment methods to client characteristics (Szapozcnik, Scopetta, & King, 1978). A variation of this modality, one-person family therapy, was seen as a more effective treatment for families with an adolescent drug-abusing member (Szapozcnik, Foote, Perez-Vidal, Hervis, & Kurtines, 1978). This short-term modality involved a maximum of 12 sessions, with no more than 2 family sessions allowed.

Few studies have been published addressing issues related to inpatient treatment and pharmacotherapy with Cubans. Rubinstein (1976) has noted some clinical peculiarities, particularly the predominance of magic and religious mystic phenomena in the manifestation of emotional problems. He indicates that, despite the frequent appearance of hallucinations and delusions, such disorders tend to be depressive rather than schizophrenic. He reports on the successful use of antidepressants to treat the pseudoperceptions in two clinical cases.

Clinical Examples

We shall now present two cases that illustrate some of the treatment issues with Cuban-Americans. (Identifying information has been changed to protect the privacy of these clients.) The first example is an illustration of a therapy conducted as part of an outpatient private practice. The second example illustrates a treatment that occurred at an inpatient psychiatric facility within a public county hospital. Sensitivity to changing cultural beliefs is a central part of the engagement and treatment in both cases. The therapist's attention to culture and socioeconomic issues in the first case produced important intergenerational accommodation and changes. In the second case, knowledge of these issues proved vital in the diagnosis and hospital treatment.

Outpatient Treatment: The Gomez Family

The Gomez family was seen by the second chapter author because the 16-year-old daughter, Lisa, was exhibiting signs of depression and unhappiness at home. Mrs. Gomez indicated at the time of the initial call that Lisa had been reared Cuban style but that she was not a "prisoner" in the home. Mrs. Gomez reported that she and Lisa had ongoing conflicts regarding the social behaviors that Lisa was not permitted (i.e., dating, going out by herself), but that recently these conflicts had intensified and Lisa had become extremely moody, irritable, and depressed. Mrs. Gomez also indicated that she realized it was a serious matter when she found Lisa's diary and read that Lisa had tried to commit suicide by taking antibiotic pills. Fortunately, Lisa only became mildly sick the day she took the pills. Mrs. Gomez did not tell Lisa that she had read her diary, but she became sufficiently concerned to schedule an appointment with a psychotherapist. Mrs. Gomez explained that her experience with a South American therapist had not been good at all. The therapist had been seen only once. Mrs. Gomez had been insulted when told by the therapist that in the United States a girl's virginity was not "such an important matter" and she should allow Lisa more freedom. Mrs. Gomez indicated that she was calling because she felt that as a Cuban the new therapist would better understand the situation.

At the outset of the initial session, the therapist met privately with both parents. Mr. and Mrs. Gomez turned out to have atypical Cuban migration characteristics, though common value structures and family backgrounds. Mr. Gomez, 64 years old, had migrated to the United States in 1944, when he was in his early twenties. He had been raised in Oriente province, had a working-class background, and came to the United States looking for better economic opportunities. He had been previously married and had two sons from his first wife. He had settled on the East Coast and owned a small grocery store in the *barrio*. Mrs. Gomez, 52 years old, came to the United States in 1956 with her family, in search of better economic opportunities but also abandoning a deteriorating political situation during the Batista regime. Her family was also from Oriente. She met Mr. Gomez in the United States and they were married in 1960. They had four children, two older boys and two younger girls. Lisa was the oldest of the two girls. Thus their previous experiences with male children had not prepared them for the value conflicts they were to encounter with the girls. Mrs. Gomez still cherished the way of raising children in Cuba, with the family getting together in the house in the country, adolescent girls being chaperoned at parties, and girls retaining their virtue until marriage.

The therapist initially joined with Mr. and Mrs. Gomez by reminiscing about the "good old times" in Cuba, stating that he remembered well how things used to be and how his parents had similarly raised his sister. He praised them for preserving their values in a relatively hostile environment. The therapist reassured them that he had dealt with this problem before and that he would be able to help the family even though they were dealing with a very real, very complex problem with no easy solutions. Lisa was then seen individually.

She was an attractive youngster who attended a Catholic high school. Lisa was an excellent student who had already been inducted into the National Honor Society. She was in much distress, but not suicidal. She spoke at length about her efforts to be like her friends and how she wished she had different parents. She felt embarrassed to tell boys who would ask her out that she could not go out with them because her parents would not let her. Instead, she would tell them that she could not go out with them because she was already busy that weekend. Of course, every weekend Lisa would despair at home, knowing that she had turned down invitations to go out because her parents would not allow her to do so. Further exploration with Lisa revealed that she spoke Spanish well and enjoyed certain aspects of the culture (i.e., Cuban food, family gatherings, and social events). Thus she was not totally rejecting of the family values. She was reassured that the therapist understood her plight and that he would try to help her, though she should not expect her parents to change very much or very quickly. Lisa was told that her problems were common among Hispanic families in general and that she was being unhelpful by telling boys who asked her out that she was "busy."

The format used in the initial session—parents and daughter seen separately—was continued in subsequent sessions. The family was not seen together until the last session, when it was time to sum up the accomplishments made in therapy. A total of eight sessions were held with the family. During subsequent sessions, work with the parents was oriented toward helping them reach some compromises that they could live with. The therapist emphasized that they should not try to change their most basic and cherished values, but that they should try to find some minor matters that they could accommodate to, taking into consideration the difficult demands of raising adolescent daughters in a very different social and cultural context. The therapist resisted giving them specific suggestions as to what they should or should not do, but exhorted them to work fast as Lisa's emotional status could deteriorate if the existing social and family pressures were to continue. The Gomezes were reminded that Lisa was an honor student who showed responsibility and motivation in her studies. He confided in them that often girls in Lisa's predicament became totally rebellious and reacted by losing their interest in school. In extreme cases, these other girls would start cutting classes and get involved with undesirable elements. In the end, involvement with drugs and teenage pregnancy were unstoppable consequences of this cycle. The Gomezes, duly alarmed, indicated that they had always been open to certain concessions—such as having a boy visit Lisa at home—but that Lisa had not gone along as she wanted to be able to go out with the boy. The Gomezes were praised for their flexibility and foresight, and the therapist remarked that it was always better for the parents to be able to meet the boys going out with Lisa, so that they would get to know them. He added that this sounded like a solid first step in seeking an accommodation with Lisa and that other steps might come later, when they felt that Lisa was ready for a little more responsibility. Lisa, separately, was told what her partents were willing to do. She resisted the idea initially, but was reminded by the therapist that it was not uncommon among Hispanic families to insist on this "dating arrangement" in the beginning, and that perhaps other concessions would follow. Again, she was counseled to warn the boy that her parents were "old-fashioned Cubans" and that they would want to meet him and talk to him for a while if he came to visit. With some hesitancy, she allowed that she might perhaps agree to have a boy come to visit over the weekend. During the next session it was learned that the boy had indeed come to visit. Both parents and Lisa discovered that their worst fears had been unfounded; the boy—who was not Cuban—related to the parents with formality and respect and did not make Lisa feel that visiting a girl at home was such a horrible thing.

Treatment proceeded along the lines described above, helping each side in the conflict understand the other side a little better and make "small" changes that in the end proved to be major concessions. Subsequent sessions dealt with other dating issues such as going to the junior prom (compromise: Father drove Lisa and her date to the prom, but they were allowed to return with another couple), double-dating, and curfew time. Upon termination, in a joint session, the Gomezes were praised for learning how to adapt to a situation that had resulted in untold grief to other

Hispanic families who proved too rigid to deal with the demands of a different culture. Lisa was praised for understanding her parents and their values better, and for "educating" her boyfriend about Cuban culture.

In examining what made treatment with the Gomez family successful, the therapist was aided by the insensitive, if well-meaning, intervention of the first therapist. That therapist challenged the parental value structure head to head at the outset of therapy and lost decisively. That intervention had been of critical diagnostic importance. It revealed the lack of parental acculturation in a rigid and traditional family structure, which, interestingly, manifested itself as a problem only when they were faced with a daughter reaching midadolesence. There was no evidence from the family history that the Gomezes' lack of acculturation had presented significant problems when their sons were growing up. Apparently, they were able to traverse that road without experiencing the pressures from the social context that they experienced with Lisa. Of course, Lisa required more vigilance and stricter enforcement because of the traditional differential child-rearing practices. The therapist's role was to help the Gomezes be more accepting of the social realities of an adolescent growing up in the United States while supporting their basic "old-fashioned" values.

Structurally, the therapist sought to dilute the mother–daughter relationship by supporting the daughter's individuation efforts and reinforcing the husband–wife relationship. Once the initial logjam was broken between Lisa and her parents, other issues were easier to deal with, in a less tense atmosphere. As Lisa experienced more freedom, her depression lifted and her disposition became more positive at home. Her parents were relieved that she ceased to be emotionally distressed and felt largely comfortable (if not 100 percent) with the decisions they had made. In the process, they found out that both of them really liked the North American boy who had first visited Lisa at home and then taken her to the prom. The Gomezes were taught, in effect, that by changing some of their practices they were being flexible and realistic, but that they would still be "good Cuban parents." The therapist created a bridge across the generational gap that would help assuage the sense of discontinuity between Lisa and her parents. The outcome was the lessening of pressure between the two cultures.

While we believe that it is not necessary to have a client–therapist ethnic match to effect change, it turned out to be helpful in this case. The family, recoiling from a previous disaster with a non-Cuban (albeit Hispanic) therapist, sought a Cuban therapist who would "really" understand their family values. The ability to speak Spanish was also critical in this case, as the parents had limited English fluency. The therapist's knowledge of Cuban family life appeared to facilitate their engagement in therapy.

In our clinical experience, we have seen many instances of effective cross-cultural treatment involving therapist and clients of mixed ethnicity, race, and culture. The key to successful clinical work is excellent clinical skills coupled with an appreciation for differences. Culture and ethnicity have many manifestations, some functional, some dysfunctional. What may be functional at one point in time may be dysfunctional at another. Ethnicity and culture are important diagnostic and treatment considerations, especially when they hinder the family in its interfaces with other social institutions.

Inpatient Treatment: The Case of Roberto

The clinical work with Roberto was supervised by the first chapter author. The actual evaluation and treatment were conducted by a fourth-year Mexican-American medical student during a psychiatry clerkship. Roberto was a 29-year-old Black Cuban male who migrated to the United States alone in 1980. He had worked as a waiter in Oregon 2 weeks prior to his psychiatric admission in California in 1982.

Roberto was brought to a psychiatric clinic by police on a legal hold for danger to self after being found wandering into traffic. He spoke Spanish at the scene, but was mute and exhibited Christlike posturing at the clinic. He did not respond to Spanish or English instructions. No past occupational, medical, nor family history could be obtained.

The initial mental status exam revealed an adequately dressed, slightly unkempt male appearing his stated age on an identification card. The patient remained mute with his head turned laterally in apparent defiance and assuming a Christlike posture. That is, he lay in bed with eyes closed and with arms extended in the form of a cross. Any attempt to move an appendage resulted in active resistance from the patient; the intention to remain in the formation he had chosen was clear. Affect, thought disorder, and cognitive functioning could not be evaluated. A preliminary medical examination revealed a healthy, well-nourished person. However, he would not cooperate with a neurological examination. Laboratory tests and the physical exam that could be conducted were within normal limits.

The initial admission diagnosis was atypical psychosis. However, it was not possible to rule out a drug-induced psychosis or a depressive episode with psychotic features. DSM-III axes II–V could not be evaluated. The patient remained mute and uncooperative with rigid posturing during his transfer to a psychiatric unit. Rapid tranquilization with small doses of a neuroleptic medication was initiated for the first 2 days of hospitalization. The patient remained in bed for 3 days. Occasionally, he said in Spanish, "Leave me alone, don't look at me." He refused to eat or drink, requiring constant nursing supervision for adequate water and food intake. By the fourth hospital day he would leave his room for meals only.

By the fifth day of hospitalization, the patient could be interviewed. He claimed he had never seen a psychiatrist in his life and there was no family history of psychiatric disorder. He had migrated from Cuba to the United States during the Mariel exodus. A friend mentioned going to the United States and he went along. However, he had regretted this decision since he arrived. The patient had been at Fort Chaffee for a year and then was placed in Oregon, where he obtained work as a waiter. His coworkers and friends were also recent Cuban refugees. About 2 weeks prior to the hospitalization, he moved to California to visit a friend and change jobs.

The patient could not remember the incident that resulted in his legal hold and subsequent hospitalization, stating he felt "very confused" and that he was "becoming crazy." He denied any drug abuse. He wanted to return to Cuba to his family and 5-year-old daughter. He felt that life in the United States was too hard and he had too much difficulty learning English. He felt sad and drained of energy. His appetite had been decreasing for the last 9 months, during which time he had lost 35 pounds. Also, he reported trouble falling asleep, and during waking hours he felt as if he were moving in slow motion.

Mental status examination on the fifth hospital day revealed a patient appropriately clothed, but unkempt. His feet were bare. His hand covered his eyes throughout the interview as he looked at the floor. He was cooperative, passive, speaking softly and mumbling his words. Moderate psychomotor retardation was evident. He displayed a depressed affect with a dysphoric mood. Thought processes were within normal limits. Thought content was depressed with feelings of helplessness and hopelessness, with no suicidal ideation. He denied auditory or visual hallucinations and showed no delusions. The patient was oriented to person, place, and time, with clear consciousness and fair concentration. Recent and remote memory were intact. Judgment was good and insight fair. In summary he appeared to be a depressed man with no eye contact and depressed ideation.

Antidepressive medications were initiated 2 days later. During this time, the change in the patient's behavior was remarkable. He showed an interest in grooming, his affect was brighter, and he was socializing with other patients. When he saw his therapist, he smiled and shook hands. With her encouragement, he began a letter to his mother. This enabled Roberto to begin talking about feelings of loss about his family and country.

> On the fourteenth hospital day, he was discharged to a halfway house. He left the hospital in good spirits, saying he knew he wasn't crazy, and that something confusing had happened, but he did not know what. Follow-up individual therapy and antidepressant medications for 6 months were arranged.

For Roberto, the crisis at hand was the migration and the stressors involved with adapting to a new environment. The alienation from his family, homeland, and culture, coupled with a change in culture and language, was a powerful stressor. He had been experiencing signs and symptoms of depression since his move away from Cuba, but these were held in check at Fort Chaffee. His evaluation and treatment were unusual because of the limited information available on him. In this case, pharmacological and psychosocial therapies were integrated to produce a successful outcome. Pharmacotherapy targeted psychotic and depressive symptoms. The psychosocial treatment was aimed at facing the loss and facilitating his adaptation to a new environment by connecting with support groups and schools and supporting his interest in working. Treatment enabled Roberto to get in touch with his culture in a supportive social milieu. Cognitive reintegration was aided by cultural elements (e.g., use of Spanish in therapy, discussion of his family in Cuba, reviewing events of leaving Cuba and life in the United States) reinforced by his therapist.

The context of the treatment deserves mention. The patient was hospitalized in a psychiatric unit that specializes in the treatment of Latino patients. A psychiatric team composed of bilingual and bicultural professional staff sensitive to the special needs of Latinos is an integral part of this program. The patient participated with other monolingual and bilingual Spanish-speaking patients in groups, occupational therapy activities, and so on. Bilingual nursing staff were also available.

Nontraditional Treatment

There appears to be a large discrepancy, possibly due to a social desirability response bias, between survey reports and anthropological findings regarding the use of *santeros* for mental health problems. In Diaz's (1980) study, only 1 percent of the respondents in Miami and Union City–West New York admitted to utilizing a *santero*. However, 7 percent of the Miami respondents and 24 percent of the Union City–West New York respondents indicated they would go to a *santero* if needed, demonstrating a wider acceptance of *santeria* than was initially suggested by utilization patterns. In the Rogg and Cooney (1980) study in West New York, only 5 percent of the respondents who admitted to having had nervous or emotional problems indicated that they had sought the services of a *santero* or *espiritista*. Yet Sandoval (1977) asserts that *santería* is flourishing, especially among the socially mobile, middle-class-aspiring Cubans, who in pre-Castro times were "in the lower-middle and lower strata" (p. 61). Sandoval (1979) points out how *santeria* provides an externally oriented treatment model for a variety of complaints to persons who exhibit denial as a prominent defense mechanism. As with the use of *espiritistas* among Puerto Ricans and *curanderos* among Mexican-Americans, it is not uncommon to find Cubans who visit family physicians and *santeros* at the same time in order to "cover all the bases."

CONCLUSIONS

Cubans in the United States are a heterogeneous group reflecting a diversity of socioeconomic, educational, and occupational conditions as well as varied migration characteristics. While we have striven to present a global picture of this group of immigrants, clinicians working with Cubans—or with any other ethnic minority—should refrain from making a priori judgments about the specific individual or family they are about to see for the first time. What may be "characteristic" of the group may not necessarily apply to the individual. The descriptions of the culture and the group offered in this chapter should serve as a broad spectrum of colors on a canvas still in need of individual brush strokes to flesh out relevant dimensions for assessment and treatment.

Whereas a recent focus has been on acculturation as the basis of disruption in the Cuban family, this explanation is not consistent with the incidence of drug abuse and adolescent conflicts in other more acculturated groups in the United States. More cross-cultural research needs to be done in order to assess the relative importance of acculturation variables in causing mental health problems. The relative importance of acculturation may also need to be revised, given the social and economic characteristics of Cubans in Miami. Portes and Bach (1985) have pointed out that—in Miami—"the average immigrant does not need to go beyond the physical and social limits of the enclave to carry out many routine activities" (p. 199). It may well be that many Cubans in Miami who speak and understand little or no English and who otherwise exhibit no strong signs of acculturation to the host culture are well adjusted and happy with their lives. Inasmuch as they are able to transact effectively in Spanish with other significant institutions in their environment (i.e., school, health clinic, hospital, work center, recreation sources, etc.), they may not be subject to acute acculturation stress. While the lack of acculturation may play a role in intergenerational family conflicts (as with the Gomez family), other family dimensions should not be ignored or downplayed.

In conclusion, Cubans show a moderately good adaptation to life in the United States. Cubans remain a close-knit group. Family and social ties remain strong. After stabilizing from the disruptive crisis of the migration, the problems to be encountered are likely to be similar to the problems and stresses encountered by the mainstream North American society (drug and alcohol abuse, divorce, etc.). Our knowledge base concerning the epidemiology, evaluation, and treatment of health and mental health disorders remains limited, despite the large number of studies conducted with Cuban-Americans. The challenge ahead is developing a solid empirical base upon which to build effective cross-cultural prevention and treatment programs.

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13 Counseling Puerto Ricans
Some Cultural Considerations

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Puerto Ricans comprise a significant percentage of potential clients for many counselors. The migration of Puerto Ricans to the mainland over the years has created cultural differences between Puerto Ricans raised in Puerto Rico and those raised in the U.S., but both groups are at a disadvantage in the dominant American culture. Migration back to the island in recent years is creating some problems for Puerto Rico, so Puerto Ricans often find prejudice both here and there. In this article the author, who married into a Puerto Rican family, discusses some values and traits that characterize Puerto Ricans and the behaviors that emerge from these traits. He offers practical suggestions for those counselors who have Puerto Rican clients.

In recent years the educational world has become increasingly concerned with students whose cultural backgrounds are different from those of the dominant culture in the U.S. This concern, though belated and still insufficient, has prompted other helping professions to follow the lead. Thus there has recently been increased publication on counseling members of minority groups, writers advocating giving more attention to the needs of clients who are culturally and ethnically different.

One of the outcomes of the increased attention given minority groups has been a tendency on the part of many to lump all minority individuals together. Thus, although early legislation and educational endeavors were designed to help blacks, American Indians, Mexican-Americans, and Puerto Ricans, they often served only to identify them all as having the same needs and disadvantages. Each group has protested this treatment, and all have insisted that their uniqueness be recognized and preserved. This need to understand the uniqueness of clients from specific cultural and ethnic backgrounds motivated the preparation of this article about counseling Puerto Ricans.

Some Facts about Puerto Rico

There is a great deal of ignorance among mainland Americans with regard to Puerto Rico. A few years ago, when I was in the U.S. on sabbatical leave from the University of Puerto Rico, I brought my automobile, which had Puerto Rican license plates. A number of people asked if the car had been

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driven from Puerto Rico! Other typical questions reveal a lack of knowledge concerning this significant group in our society. Mainland Americans have asked: "Aren't all Puerto Ricans dark-skinned?" "Does one need a passport to go there?" "You won't serve me that hot and spicy food, will you?"

Puerto Rico is an island in the Caribbean, about 1,050 miles from Miami and 1,650 miles from New York. The island is about 35 miles by 100 miles and has a population of over 2.8 million. Its population density is greater than that of China, Japan, or India. Puerto Ricans are all American citizens, proclaimed so by the Jones Act of 1917. The population is a mixture of Taino Indians, Africans, and Spaniards, although the Indian influence is much more cultural than biological, as conflicts with the Spaniards practically decimated that group. Skin colors range from as white as any Scandinavian to as black as the darkest African, with all shades and mixtures in between.

It is impossible in this article to clear up all the myths and misunderstandings about Puerto Rico and Puerto Ricans. Indeed, there is currently much study, debate, and conflict regarding many issues of Puerto Rico's culture, identity, and political future. (Readers will find relevant material cited in the list of suggested readings at the end of this article.) These larger issues will not be easily resolved, but the present reality concerning Puerto Ricans is crucial for today's educators and counselors. In order to perform in a helpful and ethical way in assisting clients to grow and make viable decisions, a counselor must recognize personal prejudices and erroneous assumptions.

The problem of understanding Puerto Ricans is confounded by the fact that today there are really two groups of Puerto Ricans. From a crowded island not overly endowed with natural resources beyond its people and its climate, thousands of Puerto Ricans have come to the mainland, especially in the period since World War II. Many have stayed. Scarcely a state is without any Puerto Ricans, and some places, such as New York City, Boston, Hartford (Connecticut), and several areas in New Jersey, have large numbers of Puerto Ricans. Many have raised families on the mainland, and these second- and third-generation Puerto Ricans are different in many significant ways from those who were raised on the island.

The mainland-raised Puerto Rican, sometimes called Neo-Rican, is generally English-dominant with respect to language. This Puerto Rican has adapted, as one might expect, to the unique environment of the urban setting but has retained a strong influence from and linkage to a primarily Latin American setting. Thus, having been brought up in another climate, with another language, with different fears and aspirations, and perhaps often with a different reference group, the mainland Puerto Rican is understandably different from the island Puerto Rican. Yet the culturally dominant group in the U.S. defines all Puerto Ricans in the same way, and the Neo-Rican often suffers from the same prejudices inflicted on the recent arrival from San Juan, Ponce, or Ciales.

In many ways, however, Puerto Ricans from the mainland and those from the island do share common cultural characteristics. As dangerous as generalizations can be, it is important for counselors to consider some of the qualities a Puerto Rican client might possess.

Cultural Characteristics

There are certain values and traits that are generally agreed on as being linked to the Puerto Rican ethos. Chief among these are *fatalismo, respeto, dignidad, machismo,* and *humanismo* (Hidalgo undated; Wagenheim 1970). Wells (1972) has added *afecto* to this list. (See the glossary at the end of this article for definitions of Spanish words used.) These cultural attributes are important to any group, and a wise counselor should have some understanding of them. The reader who has difficulty conceptualizing these terms may find it helpful to empathize with what the Puerto Rican experiences on entering an alien culture. The following explanations may help.

There is a certain amount of overlap in the words used above. *Dignidad* and *respeto,* which have to do with the dignity of an individual and respect for those deserving of it, are interrelated concepts. *Machismo,* generally connoting male superiority, is also part and parcel of the other cultural traits. Because these concepts are so central to the Puerto Rican as an individual and as a representative of a culture that is—at least politically—bound to this country, it is very important that the counselor understand how some of these attributes are translated into behaviors. The behaviors discussed apply in some degree to most Puerto Ricans, but in some instances they may be less typical of second-generation Puerto Ricans on the mainland.

Typically the Puerto Rican is highly individualistic, a person who is not used to working in concert with others, following in single file, and, in general, organizing in ways that Anglos would call "efficient." Whether in a traffic jam or a line of patrons in a bank, a Puerto Rican may break line and take a position ahead of others. But the Puerto Rican will also offer another person the same privilege, being much more tolerant than Anglos of this demonstration of individuality.

Another characteristic of Puerto Ricans is their demonstration of love and tolerance for children. It is rare that a baby or tot, taken down any street in Puerto Rico, is not exclaimed over, chucked under the chin, and generally complimented. This love for children is stronger than its stateside equivalent; generally speaking, in fact, the family unit is stronger among Puerto Ricans. Perhaps because of the love for children, illegitimacy is not frowned on or punished among Puerto Ricans. It is not unusual for families to add to their broods with nephews, nieces, godchildren, and even the children of husbands' alliances with mistresses. It is therefore difficult for the Puerto Rican arriving at a mainland school to understand all the fuss about different last names and shades of skin color and all the confusion about birth certificates among siblings.

The characteristic of gregariousness, a trait common to nearly all Puerto Ricans, often dismays many Americans, who view it as excessive when compared with their own culture. The existence of large families and extended families, the *compadrazgo* (godparent) relationship, and life on a crowded island are probably causes as well as effects of this gregariousness. Puerto Ricans love to talk, discuss, gossip, speculate, and relate. No one needs an excuse to have a fiesta. Music, food, and drink appear instantly if someone comes to visit. Group meetings, even those of the most serious nature, often take on some aspect of a social activity. I remember more than one dull and pedantic committee meeting at the University of Puerto Rico that was saved from being a total loss because refreshments and chatting were an inseparable part of the meetings. A colleague used to reinforce attendance at meetings in her office by furnishing lemon pie and coffee.

"Puerto Ricans are seldom found in professional or managerial jobs; they are usually working in low-paying, menial occupations, to an even greater degree than blacks."

Puerto Ricans' hospitality is related to their gregariousness. In the poorest home in a San Juan slum or in a remote mountain shack, a visitor will be offered what there is or what can be sent out for on the spot. And it is not good manners to refuse this hospitality; it is offered from the heart, and refusal is rejection. The visitor in this situation will give more by partaking of the hospitality than by bringing a gift.

As might be deduced from the preceding comments, Puerto Ricans are sensitive. Social intercourse has significant meaning, and Puerto Ricans typically are quite alert to responses they evoke in others and to others' behavior, even behavior of a casual nature. Often Puerto Ricans avoid a direct confrontation, and they do not like to give a straight-out no to anyone. Marqués (1967) is among those who have described Puerto Ricans as passively docile, and indeed docility is a noticeable Puerto Rican characteristic. Silén (1971), however, has interpreted this characteristic as actually having aggressive overtones, pointing out that historically this docility was simply a refusal to engage in battles that were impractical. Silén has also reminded us of some of the past and present revolutionary stirrings of the "docile" Puerto Rican. Whichever interpretation is accepted, there is evidence that there has been some change in this behavior, especially among younger Puerto Ricans on the island and those Puerto Ricans who have been raised on the mainland.

Puerto Ricans on the Mainland

For most readers of this article, the Puerto Rican living on the mainland is likely to be of greatest interest and relevance. There are approximately two million Puerto Ricans living in the U.S. They come to the mainland primarily for jobs. They generally do not intend to remain here and, as economic conditions for the family improve, increasingly return to the island. In recent years Puerto Rico has made some economic progress and some advances in creating jobs, and thus Puerto Ricans, who typically aspire to live in Puerto Rico, find it increasingly attractive to go back.

This return migration has created some economic, social, and educational problems for Puerto Rico. For example, when younger Puerto Ricans who have been raised in New York City or other areas return to the island, they face certain cultural assimilation problems not at all unlike those their parents faced when they came to the mainland. English-dominant young people must master Spanish for school, work, social life, and participation in family and civic affairs. These youngsters' modes of behavior are often in conflict with the attitudes and values of grandparents, uncles, and the general society. Some efforts are being made to deal with these conflicts, including the establishment of special classes given in English and even the employment of a bilingual counselor or two, but the island's resources are too limited to permit extensive help in this regard. It is fair to say, however, that the Puerto Rican returning to Puerto Rico is treated considerably better than the islander who comes to the U.S. mainland.

Puerto Ricans coming to the mainland often encounter prejudice. Part of this seems to be due to the fact that they are "foreign"; most Americans—even those whose parents were born in another country—are inclined to be cool, to say the least, toward people different from themselves.

"A person's name is that person, and a counselor's mispronouncing it—whether through carelessness or laziness—can easily be construed as the counselor's lack of interest in the client."

Certainly racism is another significant element in the prejudice against Puerto Ricans. Senior (1965) has reported:

> Census figures show that fewer non-white Puerto Ricans come to the States than whites, in comparison with their proportion of the population, and a special study indicates that a larger percentage of the non-whites return to their original homes after a sojourn on the mainland. (p. 46)

But problems for the Puerto Rican are not limited to prejudice. For those young people newly arrived in the States or born here of Puerto Rican parentage, the generation gap becomes compounded by what Senior has called "second-generationitis." These youngsters must contend not only with the expectancies and pressures of a different and dominant culture but also with conflicts of values representing two different cultures. Mainland Puerto Ricans may not be able to identify completely with the Puerto Rican-culture, but neither are they a part of the dominant mainland culture. Social scientists often refer to this situation as the "identity crisis" of the Puerto Rican in the States.

As has been shown in the tragic treatment of blacks in the U.S., social and personal prejudice against a group is generally accompanied by a lack of economic opportunities for that group. Puerto Ricans are seldom found in professional or managerial jobs; they are usually working in low-paying, menial occupations, to an even greater degree than blacks. There are many causes for this. The low educational levels of Puerto Ricans on the mainland is undoubtedly a significant factor. Prejudice, suspicion, language difficulties, and the familiar self-fulfilling prophecy of low aspirations leading to lowly positions also play heavy roles in maintaining the Puerto Rican on the bottom rung of the economic and vocational ladder.

Practical Considerations for the Counselor

The following suggestions offered for counseling Puerto Ricans are based on my eleven years of experience as a counselor in Puerto Rico and on those human relations tenets to which all counselors presumably subscribe. The suggestions may seem simple and obvious to the reader; they are purposely so. They are intended as exhortations for those who are thoughtless, as reminders for those who forget, and as reinforcements for those who truly attempt to accept and understand their clients.

Examine your own prejudices. Counselors should consider their attitudes toward poor, rural, Spanish-speaking, racially mixed, culturally different clients. Knowledge alone cannot overcome prejudice, and an intellectual understanding expressed with emotional distaste will only serve to exacerbate the situation. If a counselor has negative stereotyped feelings about Puerto Ricans, it is not likely that his or her counseling relationships with them will be open and warm.

Call students by their right names. In Spanish, people are given two last names. The first last name is from the father's side of the family, the second from the mother's. The American custom is to look for the last word, and this becomes the last name. If this logic is followed with Latins, a student named Angel Rodriguez López gets called Angel López, thus dropping his father's family name. Not only might the father and son be understandably insulted by such cavalier treatment, but the boy's identity—in a real as well as a cultural sense—is in question. For those who fervently desire to maintain their cultural and personal identities without being antagonistic to the larger society, acknowledgment of the correct name can be critical.

Another element in this linguistic area is simply pronouncing names in reasonably accurate ways. Even though other students and staff may pronounce names inaccurately, it would seem that a counselor who espouses the establishment of good relationships might make a special effort in this area. A person's name *is* that person, and a counselor's mispronouncing it—whether through carelessness or laziness—can easily be construed as the counselor's lack of interest in the client. Counselors can check with a client about pronunciation. (Spanish, incidentally, is much more consistent in pronunciation than English, because each vowel is pronounced the same way in all words.)

Work with the family. For the Puerto Rican, the family is much more important than it is for the typical American. If possible, the counselor should deal not only with the young person but also with the family, getting to know them as well as the youngster. If this is not possible, the counselor can at least talk with the client about his or her family. Among Puerto Ricans, the family and extended family are often sought out for help more readily than is a counselor; research, in fact, indicates that the family is the source of greatest help (Christensen 1973). The counselor should realize that others are helping and should work with them, understanding that each person has something to offer. Ignoring this fact is equivalent to refusing to recognize that a client is also receiving help from another professional.

Refrain from using the child as an interpreter. In cases where a parent knows little English and the child is reasonably bilingual, it is a temptation to rely on the son or daughter to carry a message to the parent. This should be avoided whenever possible. Even though it might be a source of pride for the child, it might place the parent in a dependent position, preventing the parent from entering into the counseling relationship as a full partner. There is an additional concern: the possibility that the child might twist others' statements. Puerto Rican families are close, but a situation in which a parent continually communicates only through the child can alter relationships and create family strains.

Understand that to the Puerto Rican you are the foreigner. One cannot jump into instant relationships. The counselor must give the client time to know and trust him or her. To facilitate this, the counselor may need to meet the client outside of the school or the counselor's office. The counselor should share and be somewhat self-disclosing, revealing some things about his or her family, ideas, home, and so on, in order to give the client a chance to know the counselor as a person. Counselor self-disclosure can be a sign of trust for any client, but it is even more crucial where some feeling of "foreignness" is present in both counselor and client.

Understand the concept of "hijo de crianza." This term refers to someone other than the child's parents raising the child—either family members (such as an aunt or a grandmother), extended family members (such as a godparent), or even a friend or neighbor. It also may refer to a family's raising the father's children from another marriage or even from outside a legal union. Counselors must not apply their moral values in such situations. The child is the parents' child through love and acceptance, and exact relationships are not that important.

Be patient. This should be a given for all counselors with all clients, but it is especially true when counselors desire to establish any kind of relationship with clients from a different culture. Puerto Ricans have many obstacles to overcome, some of which are not of their own making. In the counseling relationship, counselors have to overcome some of these same hurdles. Counselors must demonstrate their credibility, honesty, and reliability, just as their Puerto Rican clients must do almost daily in an alien society. The difference is that the counselor is in a more advantageous position, and therefore the counselor's initiative is crucial. The Puerto Rican client may expect the counselor to be prejudiced, arrogant, and lacking in knowledge about Puerto Ricans. The burden is on the counselor to demonstrate that these expectations will not be fulfilled.

The Fruits of Labor

The counselor who works with Puerto Ricans of any age and in any setting may find some difficulty in doing so. But counselors who are willing to learn will find the effort rewarding. Puerto Rican clients need counselors as much as—or more than—other clients do. Moreover, in the final analysis, we Americans need them also. For they, along with all people of differing ethnic and cultural backgrounds, offer all of us a richness that even a wealthy country cannot afford to be without.

Glossary of Spanish Terms

afecto literally means "affect." Refers to the affective side of life—warmth and demonstrativeness.

compadrazgo refers to the relationship entered into when a person becomes a godfather (*padrino*) or godmother (*madrina*). This person then becomes a *compadre* or *comadre* with the parents of the child and traditionally not only takes on certain responsibilities for the child but also is closely related to the entire family of the other person. In some cases this may also involve even other *compadres*, and then the total relationships derived from this system of *compadrazgo* are complex and far-reaching and form the basis fo. what sociologists term the extended family, which is so characteristic of many societies.

dignidad dignity, but of special importance in Puerto Rico and closely related to *respeto*. One can oppose another person, but taking away a person's respect or dignity in front of others is about the worst thing one can do.

fatalismo fatalism.

humanismo humanism, especially as contrasted with the more pragmatic set of the typical Anglo.

machismo related to male superiority and, in its original form, implying the innate and biological inferiority of women. Characterized as an overcompensatory reaction to the dependence-aggression conflict, *machismo* is acted out through fighting and sexual conquest.

respeto signifies respect, especially respect for authority, family, and tradition.

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Vocational Rehabilitation of People of Hispanic Origin

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This study presents exploratory, descriptive data from the Rehabilitation Services Administration for fiscal year 1989 for the purpose of identifying and exploring the experience of people of Hispanic origin with disabilities in state-federal vocational rehabilitation service delivery systems in the United States and its territories. Included is a demographic description of the Hispanic population, a review of the rehabilitation literature on racial/ethnic groups with emphasis on Hispanics, and information on estimates of disability prevalence among people of Hispanic origin. This study identifies and describes selected characteristics of Hispanics who applied for and/or participated in the vocational rehabilitation system. A "Hispanic origin" region was identified that accounted for 89% of the rehabilitation data on Hispanics. This region consisted of nine states (i.e., California, Texas, New York, New Jersey, Illinois, Arizona, New Mexico, Florida, and Colorado) and the island of Puerto Rico. It was estimated that there could conceivably be over two million Hispanic-origin people with disabilities in the United States. However, in fiscal year 1989, the state-federal rehabilitation system rehabilitated only 17,454 Hispanic-origin people. This study raises the following questions: How can the system reach the potential pool of Hispanic-origin people with disabilities who require services? What services will they require? What factors predict successful or unsuccessful rehabilitation of those Hispanic-origin people with disabilities who do reach the system? The need for further research is emphasized and recommended.

The Hispanic population presents a provocative challenge to human services delivery systems attempting to assess and meet the needs of this diverse population. The challenge is especially difficult in the areas of health, disability, and vocational rehabilitation. In the field of rehabilitation, subgroups of people with disabilities are referred to as double minorities. Virtually nothing is known of the interaction effects of multiple group membership, especially dual membership in disability and racial/ethnic groups. This is due, in part, to a lack of systematic exploration and research of minority group involvement in health/disability/rehabilitation delivery systems. This is particularly true for people of Hispanic origin.

State-federal agency personnel, if they aren't already, will become more aware of Hispanics' participation in their programs as the population grows. It is anticipated that the Hispanic population will be the largest minority group in the nation by the year 2000. Unless more is learned about the disability and rehabilitation experience of people of Hispanic origin, it will be very difficult, if not impossible, to assess the impact of the Americans with Disabilities Act on this group.

We can surmise that with the increasing Hispanic population, there should be an accompanying increase in demand for vocational rehabilitation services. But we have yet to examine the Hispanic experience in state-federal vocational rehabilitation agencies. The urgency of the need for such research is indeed notable when we examine

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the potential and existent prevalence of disability among Hispanic-origin people in the United States.

The purpose of this article is to present preliminary data on the experience of people of Hispanic origin in state-federal vocational rehabilitation programs across the nation. This study begins with a description of Hispanics as a sociological group. This is followed by a discussion of the factors that contribute to the designation of this group as an at-risk population. Next is an examination of disability prevalence among Hispanics, followed by a review of rehabilitation literature on Hispanics. Finally, a presentation is made of descriptive data of Hispanics' experience in vocational rehabilitation state-federal agencies based on Rehabilitative Services Administration data for fiscal year 1989.

THE HISPANIC POPULATION: A SOCIOLOGICAL ENTITY

Because 90% of the Hispanic population typically is categorized as white in racial classifications, it is difficult to document prevalence or incidence of this group's experience in social systems. Furthermore, the intraethnic diversity and complexity of the Hispanic population frequently belies the fact that they constitute a sociological group. The diversity includes differences in acculturation, socioeconomic level, educational attainment, country of origin, generation, etc. While there are within- and between-group differences regarding self-identification and other characteristics, to a greater or lesser degree, the Hispanic population shares a common language, i.e., Spanish, and a common history, i.e., discrimination and economic exploitation.

The term "Hispanic" is now widely used by the state and federal system in identification and data gathering. But this was not always the case. The category "Hispanic" is a confusing and controversial term both to consumers, practitioners, and researchers. Yet, rehabilitation counselors are faced with uncertainty as to how to identify or refer to Hispanic clients when interacting. Hispanics themselves differ in the meaning that identifying labels have and may identify themselves in a variety of ways, e.g., Mexican, Chicano, Mexican American, and Latino. This confusion about the meaning of the various labels is filled with scientific and political limitations and controversy (Leal, 1990).

The diversity of the Hispanic population presents unique conceptual and methodological considerations to researchers and policy planners. When research results are interpreted, there is a methodological ambiguity as to whether the results can be generalized, and, if so, to which Hispanic subgroups. Some academic scholars propose the term "Latino" as a more appropriate and empowering term because it is self-imposed rather than externally imposed and thus more reflective of the collective identity (Padilla, 1985).

In March, 1991, this population made up 8.6% of the total U.S. population, totaling 21.4 million (U.S. Bureau of the Census, 1991). This was an increase from 20.1 million in 1989 (U.S. Bureau of the Census, 1989). Almost 63% of the Hispanic population was of Mexican origin, while 13.8% was of Central and South American origin, compared to 12.7% in 1989; 11.1% was of Puerto Rican origin, a decrease from 11.8% in 1989; 4.9% was of Cuban origin, a decrease from 5.3% in 1989; and 7.6% was of "other Hispanic" origin, a decrease from 7.8% in 1989. "Other Hispanic" origin referred to individuals who identified themselves generally as Hispanic, Spanish, Spanish-American, Hispano, etc., or whose origins are in Spain. Most Mexican-origin people lived in the southwest United States, Cuban-origin people in Florida, and Puerto Rican-origin people in New York and New Jersey. However, it is also true that all Hispanic subgroups resided throughout all areas of the United States.

SOCIAL DEMOGRAPHICS OF HISPANIC-ORIGIN PEOPLE

From the 1986 *Report of the Secretary's Task Force on Black and Minority Health* and the U.S. Bureau of the Census March, 1990, *Statistical Brief*, we know that compared with the United States population as a whole:

1. Hispanics show dramatic subgroup differences in age, education, and economic status ranging, for example, from a younger Mexican-origin population to an older Cuban-origin population.
2. Hispanics are generally much younger and have high fertility rates.
3. Hispanics tend to have high unemployment rates and concomitant social ills that accompany poverty. In 1988, 27% were living in poverty compared to 12% for non-Hispanics. In 1989, they were twice as likely to receive public assistance.
4. Hispanics have significantly less education, adversely affecting vocational alternatives, with resultant employment that is physically demanding and dangerous.
5. Hispanics are subjected to discrimination in education, employment, and housing.
6. Hispanics are predominantly urban (88%) and live in every state of the union. There is a notable concentration of Hispanics in the southwestern United States (i.e., California, Texas, Arizona, New Mexico, Colorado). In the east and south, they are concentrated in New Jersey, New York, and Florida. Additionally, over 3,000,000 Hispanics live on the island of Puerto Rico.
7. Hispanics share, to a greater or lesser degree, Spanish as their first language. Yet while 80% of all Hispanics identify Spanish as their first language, only 10% speak Spanish. This presents linguistic obstacles in assessment and delivery of human services.
8. Substance abuse is a social problem within high-risk segments of the Hispanic population (Leal, 1990).
9. There is evidence of under-utilization of mental health services. (Arnold and Orozco, 1989; U.S. Department of Health and Human Services, 1986; Fierro and Leal, 1988; Leal, 1990).
10. Contrary to general belief, migrant health issues are not the major health problem of Hispanics. Migrants represent only 1% of the total Hispanic population.

Because of these characteristics, Hispanics, along with other minority groups, have been labeled "disadvantaged." The problem with this term is its pejorative and causal connotation. The culture mistakenly is seen as the underlying cause of the problem rather than as, in part, a result of institutionalized practices that maintain inequities in service delivery. Instead, the effects of culture must be set apart from the effects of socioeconomic status (Rivera and Cespedes, 1983).

REVIEW OF REHABILITATION LITERATURE ON RACIAL/ETHNIC GROUPS

Information on prevalence and incidence rates of disability among racial/ethnic groups is limited. Part of the problem are the various definitions of disability. This problem is intensified by severe methodological limitations of using race as a variable or analytical tool. Wright (1988) estimates that the proportion of people with disabilities will increase by 20-50 million in the next several decades.

As sociological entities, racial/ethnic groups have been largely ignored in the field of disability and rehabilitation. Of the information that does exist, the bulk of attention has been on blacks (i.e., African Americans). However, a review of the literature also revealed a focus in several publications on the "culturally handicapped" (Johnson, 1970; Raphael, 1972; Katz, Reagles, and Wright, 1973; Cook, 1975; Rosow, 1976). This mirrored the policy emphasis in the sixties on the "culturally disadvantaged." This was followed by a shift in population emphasis in the 1973 Rehabilitation Act from the "culturally disadvantaged" to the physically handicapped (Berkowitz, 1987).

The only systematic research found on utilization of rehabilitation systems by minority groups was by Atkins and Wright (1980). In their controversial study, they examined the participation of blacks in the public vocational rehabilitation system by analyzing national closure data for fiscal year 1976. They compared blacks with disabilities to whites with disabilities on the following dimensions of the state-federal vocational rehabilitation process: 1) education at referral, 2) primary source of support at referral, 3) weekly earnings at referral, 4) reasons for nonacceptance referred, 5) patterns of service, 6) funds spent for case services, and 7) weekly earnings at closure. Their study led to the following conclusions:

1. A larger percentage of black than white applicants were not accepted for service or were closed without being rehabilitated.
2. Blacks had lower levels of education, were poorer, and were more likely to be on public assistance.
3. Blacks were more likely to be at lower income levels even when "successfully rehabilitated."
4. Blacks were more likely to not be accepted for service because of failure to cooperate.

Bolton and Cooper (1980) were critical of this study primarily on methodological grounds. They supported ". . . service provision to an identifiable group of disadvantaged clients" yet pointed out that ". . . the goal of [vocational rehabilitation] services is to equalize opportunities to disabled persons regardless of race or ethnic origin" (p. 49).

Literature on Hispanics with Disabilities

The following five rehabilitation journals were surveyed beginning with the year 1970 for articles on Hispanics: *The Rehabilitation Counseling Bulletin, The Journal of Rehabilitation, Rehabilitation Literature, Journal of Applied Rehabilitation Counseling*, and *American Rehabilitation*. Only ten articles were found. Of those, six were published after 1987 and half of those were published in a 1988 special issue of the *Journal of Applied Rehabilitation Counseling* devoted to multicultural issues in rehabilitation. The latter was the first special issue of its kind in the rehabilitation counseling literature. The thrust of the earlier publications was on the culture and its affect on the rehabilitation process. Later publications began to look at how the system and its services could meet the needs of minority groups.

In what appears to be the earliest publication concerning Hispanics with disabilities, Roberta Church (1970) published "Migrants: The Last Human Frontier." This article described vocational rehabilitation services targeted at migratory workers as authorized under Section 304 (c) of the 1973 Rehabilitation Act. Special needs were identified, including the need for outreach services to recruit clients and for bilingual health services.

Rivera and Cespedes (1983) described how family, language use, and health problems of Hispanic migrant and seasonal farm workers affected rehabilitation counseling interventions. They acknowledged the degree to which traditional Hispanic culture was manifested as a function of acculturation, socioeconomic class, and the general diversity within the Hispanic culture. They emphasized the need for training on cultural specifics of the Hispanic culture so that rehabilitation counselors might have specific knowledge of the Hispanic culture in order to provide culturally sensitive rehabilitation services.

Arnold (1983) noted the lack of research regarding Hispanic attitudes toward handicapping conditions. He discussed the importance of taking into account the cultural distinctions between Hispanic subgroups, including intragroup variation based on region, socioeconomic status, and educational level. He cited the need for research on rehabilitation resource utilization. He recommended the study of cultural characteristics of the population to assess their unique impact on the effective delivery of services.

Pape, Walker, and Quinn (1983) reported a study that concluded that Hispanics were underrepresented in vocational rehabilitation caseloads in New York City. Kunce and Vales (1988) focused on Mexican-origin Hispanics "and how their heritage may adversely influence the ways in which they adjust to rehabilitation services in the United States" (p. 97). Using descriptions of rehabilitation programs in Mexico as a baseline, they concluded that Mexican Americans may have unrealistic expectations of rehabilitation services in the United States.

Cuellar and Arnold (1988) discussed the importance of acculturation of Mexican Americans to rehabilitation programming. The role of the family as necessary to rehabilitation success was highlighted. Four human services delivery models were identified. These models emphasized various levels of Spanish language facility necessary in interacting with Hispanic clients as well as varying levels of culturally sensitive services. It was hypothesized that these models probably exist in the vocational rehabilitation service delivery system, but no specific programs were identified. Medina et al. (1988) cited personal correspondence from a supervisor in the Colorado Rehabilitation Services advising that a higher proportion of Hispanics were closed in 08 status (ineligible for services) than Anglos.

In a special issue devoted to multicultural issues in rehabilitation counseling mentioned earlier, the coeditors focused on four U.S. minority groups (blacks, Asians, Native Americans, and Hispanics) (Leal et al., 1988). It was pointed out that these minority groups share a struggle with structural and institutional barriers in American society.

Santiago's (1988) study of the provision of vocational rehabilitation services to blind and visually impaired Hispanics in New Jersey revealed that Hispanic clients had limited participation in vocational rehabilitation programs. Hispanics were more likely to be involved in counseling, with less than 1% involved in programs such as college counseling, career development, and business enterprises. Regarding rehabilitation outcomes, she reported that the number of closures for whites was 10 times higher than for Hispanics. She concluded that only a small fraction of Hispanics, about 10% of the active cases, had been successfully rehabilitated. Fierro and Leal (1988) studied industrially injured Mexican-origin workers in California and found there was more depression, lower self-esteem, and increased dependency the greater the elapsed time between work injury and referral for vocational services.

The importance of understanding substance abuse as a primary or secondary disability was the focus of Leal's 1990 publication. Alcohol abuse has become a major health problem among a high-risk segment of the Mexican-origin Hispanic population. The most recent addition to the literature on Hispanics with disabilities is Trevino's (1991) article which emphasized the cultural characteristics of Mexican Americans with a focus on the importance of the family to rehabilitation planning.

As the review of the literature reveals, published information about Hispanics' utilization of vocational rehabilitation services is very limited. There is a scarcity of research on the topic and the scope of the information that does exist is limited. The studies that do exist are primarily descriptive and, though informative, they are neither explanatory nor research based. No studies were found that provided information from a national perspective. However, the studies mentioned do provide preliminary evidence that people of Hispanic origin with disabilities may have limited acceptance to and success in vocational rehabilitation delivery systems.

Disability Prevalence Among People of Hispanic Origin

Disability prevalence is one source of data from which potential demand for vocational rehabilitation services can be estimated (Berkowitz, 1967). Though data is scant, there is evidence that Hispanics have a higher rate of physical, mental, and emotional disabilities compared to the general population (National Institute on Disability and Rehabilitation Research, 1989; Bowe 1981a, 1984). Approximately 8.4% of working-age Hispanic adults, or 1 in 12, reported having a health condition that prevented or limited them from working. The percentage was higher (8.6%) for Hispanic women compared to Hispanic men (8.2%). The only profile available of the typical person of Hispanic origin with a disability has been generated by Bowe (1981b) as follows: female, 40 years old, married, has a ninth-grade education, is not working part or full time, and had more than $3,500 in income from all sources in 1980.

More recent data reveals an increase in disability prevalence among Hispanics. LaPlante (1988) conducted a statistical analysis of the National Health Interview Surveys 1983–1985 and found that 9.8% of Hispanics reported limited work activity or inability to work due to chronic medical conditions. These conditions included tuberculosis, neoplasms, diabetes, psychoses, multiple sclerosis, all heart conditions, and arthritis, among several other conditions. Using LaPlante's data, by interpolation, it is conceivable that in 1989 more than two million Hispanics had a disability that prevented them from working and could have benefited from vocational rehabilitation services.

National Data

The purpose of this section is to present national data from the Rehabilitation Services Administration (RSA) for fiscal year (FY) 1989 on rehabilitation applicants of Hispanic origin. This information was obtained from RSA in July, 1991, as FY 1989 totals were nearing completion, thus comprising preliminary final tabulations. These data were based on reports from all RSA regions including each state and U.S. territories. The figures include data on all individuals of Hispanic origin accepted by these agencies, as well as data on those people of Hispanic origin who were successful and unsuccessful in the rehabilitation process for the year. The baseline number for each item varies because of variation of state reporting on individual items.

Information on how Hispanics fared in vocational rehabilitation programs from application to closure across the nation and in Puerto Rico has not been systematically analyzed, although the data are collected by RSA. The *Annual Report to the Congress for Fiscal Year (FY) 1989* (Thayer, 1990) (required by the 1973 Rehabilitation Act) noted that 20% of all people rehabilitated were members of a racial minority group. This has been a fairly consistent proportion for several years. The *Annual Report* does not present specific caseload highlights on minority groups but noted that the percentage of Hispanics rehabilitated, regardless of racial origin, rose from 6.4% in FY 1984 to 7.2% in FY 1988. Based on FY 1989 preliminary data obtained for the present study, the percentage of Hispanics rehabilitated was 8.2%.

Among several required data, two items relate directly to race and ethnicity. One item asks for classification information into the following categories: black, Native American, Asian, and white. The other item asks for classification of potential rehabilitants into the categories Hispanic and non-Hispanic origin. These two items are not mutually exclusive; a Hispanic-origin rehabilitation applicant can be of any race.

According to the RSA data, the total number of people of Hispanic origin who applied for services in FY 1989 was approximately 49,630, or approximately 2% of the total Hispanic-origin population of 23.6 million for the mainland United States and the island of Puerto Rico combined. Sixty-two percent (30,909) men and 38% (18,721) women of Hispanic origin applied for vocational rehabilitational services. This is an interesting statistic considering that Bowe (1981) reported that 53% of working-age Hispanic women compared with 47% of men had a disability that prevented them from working. Of the 49,630 Hispanic-origin applications, 22,927, or 46%, were not accepted for services. Of the 26,703 (54%) who were accepted for services, 17,453 were rehabilitated. The remaining 9,250 were closed and not rehabilitated (Codes 28 and 30).

Almost 47% of Hispanic-origin rehabilitation applicants were never married; 32% were married, 12% were divorced, approximately 7% were separated, and 2% were widowed. Sources of referral of Hispanic-origin applicants included the following: educational institutions, 6,871, or 13.9% (66% of these were from elementary or high school); hospital and sanatoriums, 2,833, or 5.7% (49% of these were from general hospitals or rehabilitation facilities); health organizations, 4,902, or 9.9%; welfare agencies, 1,982, or 4%; other public organizations, 9,266, or 18.7% (33% of this total came from correctional institutions); other private organizations, 1,466, or 3%; self-referrals, 11,698, or 23.6%; physicians, 3,781, or 7.6%; and other individuals, 6,788, or 13.7%.

The primary source of support was reported for only 26,620 Hispanic-origin applicants. Of this total, 3,515, or 13.2%, were supported by current earnings; 12,998, or 48.8%, by family and friends; 4,455, or 16.7%, by public assistance; 140, or 0.5%, from private relief agencies; 1,011, or 3.8%, SSDI benefits; 798, or 3%, by worker's compensation; 388, or 1.5%, by public institutions; 1,929, or 7.2%, from other public sources; and 1,386, or 5.2%, from all other sources.

Table 1 reports race of rehabilitated persons in FY 1989 by Hispanic origin. The majority of Hispanics (16,146) are reported as white. Note that 20% of the Hispanic-origin RSA statistics on Hispanics come from Puerto Rico, where 99.9%

Table 1. Race of Rehabilitated Persons in FY 1989 by Hispanic Origin

Race	Total	Hispanic Origin	Non-Hispanic Origin
White	172,292	16,146	156,146
Black	37,561	661	36,900
American Indian/ Alaskan Native	1,208	60	1,148
Asian American/ Pacific Islander	2,781	562	2,219
Total	213,842	17,429	196,413

of the Hispanic-origin population is reported as white.

Table 2 summarizes disabilities reported for Hispanic-origin applicants. While 24.3% of Hispanic-origin applicants had orthopedic impairments, it is notable that a combined total of 29% were in the categories of mental illness and substance abuse.

Nearly two thirds of the rehabilitation statistics for people of Hispanic origin were data reported from Puerto Rico, Texas, and California. Furthermore, 89% of the Hispanics in the United States live in the nine states shown in Table 3. (Puerto Rico, a U.S. territory is shown for comparison.)

Table 2. Major Disability Summary by Hispanic Origin for FY 1989

	Hispanic Origin Applicants	
Disability	*n*	%
Orthopedic impairments	10,982	24.3
Mental illness	7,203	15.9
Substance abuse	5,756	12.7
Visual impairments	4,947	10.9
Mental retardation	3,825	8.5
Learning disabilities	2,690	6.0
Hearing impairments	2,586	5.7
Heart/circulatory	1,025	2.3
Absence of limbs	703	1.5
Digestive disorders	659	1.5
Genito-urinary	537	1.2
Respiratory conditions	217	0.5
All other disabilities	4,052	9.0
Total	45,182	100.0

Table 3 shows data for those states with the greatest concentration of Hispanics on the mainland United States and Puerto Rico. These states reported 300 or more rehabilitations of people of Hispanic origin in FY 1989. This table shows the distribution of applications in this region. The table shows nonacceptances, rehabilitations, and closures for those state agencies. Note that Texas blind rehabilitations were greater than the rehabilitations reported for seven of the selected agencies. Furthermore, rehabilitations in Puerto Rico accounted for 22% of the "Hispanic Origin" region depicted in this table and for 20% of all Hispanic-origin rehabilitations for FY 1989.

Table 4 shows the proportion of Hispanic compared to non-Hispanic-origin people found ineligible for vocational rehabilitation services (i.e., code 08). "Unable to locate" and "failure to cooperate" were cited as reasons for closure of proportionately more Hispanic-origin compared to non-Hispanic-origin cases. However, non-Hispanic-origin applicants were more likely to refuse services (19.8% and 27.9%, respectively). Non-Hispanic origin in this comparison includes all other racial and ethnic groups as well as whites.

Table 5 shows the distribution of mean case service costs for Hispanic-origin clients and the mean time in vocational rehabilitation for the "Hispanic Origin" region identified in Table 2. Most notable is the range both of case cost and time in vocational rehabilitation. California has the lowest case cost and least time in vocational rehabilitation, $927.10 and 14.4 months, respectively. This contrasts dramatically with Puerto Rico's case cost and time in vocational rehabilitation, which was $3,188.90 and 50.3 months, respectively. Clearly, there are regional differences even within the designated "Hispanic Origin" region.

Table 6 shows the work status at closure of rehabilitated Hispanic-origin clients compared to whites. No statistical comparisons were conducted, but clearly the proportion of whites in sheltered workshops was greater than for Hispanic-origin rehabilitants (6.2% and 3.6%, respectively). Furthermore, a larger proportion of His-

Table 3. Distribution of Hispanic-Origin Applications, Nonacceptance, Rehabilitation and Closures for Selected* State Agencies and Puerto Rico for FY 1989

State	Total Hispanic Population (Percent of State Population)†	Number of Hispanic-Origin Applications	Nonacceptance (Codes 02, 06 Combined)	Rehabilitations	Not Rehabilitated (Codes 28, 30 Combined)
California	6,672,000 (24.3)	12,009	5,438	4,107	2,464
Texas	4,313,000 (25.8)	8,879‡ 1,762§	2,969‡ 848§	3,805‡ 736§	2,283
New York	1,982,000 (11.2)	2,379‡ 133§	1,186‡ 16§	607‡ 74§	586
Florida	1,586,000 (12.7)	2,192‡ 159§	1,259	698‡ 116§	278
Illinois	855,000 (7.5)	766	344	300	122
Arizona	725,000 (20.8)	881	384	335	162
New Jersey	638,000 (8.4)	1,069‡ 77§	603‡ 24§	345§ 44§	121
New Mexico	549,000 (36.7)	1,624‡ 96§	1,104‡ 49§	310‡ 23§	234
Colorado	421,000 (13)	1,465	750	475	240
Puerto Rico	3,527,000 (99.9)	10,061	5,238	3,527	1,296
Total	17,741,000	43,552	20,212	15,502	6,490

Data obtained from Rehabilitation Services Administration incomplete although in final stages of compilation.

* U.S. Bureau of the Census, 1989.

† Selected state agencies based on those states with the greatest number of Hispanic-origin individuals in the nation.

‡ General.

§ Blind.

panic-origin rehabilitants were working in the homemaker category compared to whites (10% and 9.3%, respectively). A greater proportion of Hispanics were self-employed compared to whites (6.7% and 2.2%, respectively).

CONCLUSION

There is much to learn about the disability experience of people of Hispanic origin. Information is scarce, but one available source of information is that which is gathered by state-federal vocational rehabilitation service delivery systems in the United States and its territories and sent on to RSA. The need to know is critical given the phenomenal growth of this population which has large segments at risk, especially in health-related areas.

The primary issues are as follows:

1. Who is vocational rehabilitation serving? (i.e. racial/ethnic minority groups.)
2. How can this system reach the potential pool of Hispanic-origin people with disabilities who require services?
3. How can the state-federal system meet the needs of this diverse, rapidly growing population?
4. What factors predict successful or unsuccessful

Table 4. Nonacceptance for Vocational Rehabilitation Services Code 08 (Ineligible for Services) for Individuals of Hispanic and non-Hispanic Origin for FY 1989

Reason for Closure (All 08)	Hispanic Origin		Non-Hispanic Origin	
	n	%	*n*	%
Unable to locate	5,202	22.9	38,300	17.1
Failure to cooperate	5,219	22.9	48,069	21.4
Client refused services	4,506	19.8	62,576	27.9
Handicap too severe	1,326	5.8	15,410	6.9
No vocational handicap	1,295	5.7	14,117	6.3
No disabling condition	1,203	5.3	9,462	4.2
Client institutionalized	458	2.0	3,412	1.5
Transferred to other agency	326	1.4	3,385	1.5
Death	138	0.6	1,226	0.5
Transportation not feasible, not priority selection	77	0.4	1,044	0.5
All other reasons	3,013	13.2	27,630	12.3
Total	22,763		224,631	

rehabilitation of those Hispanic-origin people with disabilities who do reach the system?

5. What are the implications for policy planning?

This exploratory study set out to identify and describe selected characteristics of Hispanics who have applied for and/or participated in the state-federal vocational rehabilitation system. We were able to estimate a population of 225,400 people of Hispanic origin with disabilities with potential need for services. We learned that almost 17,500 Hispanics were rehabilitated in FY 1989, 20% of whom were rehabilitated in the Puerto Rico agency. In other words, there is a substantial group of Hispanics with disabilities that the state-federal system has not reached. Access is an issue.

Table 5. Distribution of Selected States' Mean Case Service Cost for All Clients and Mean Time in Vocational Rehabilitation

State	Mean Case Service		Mean Time in VR (Months)
	Cost ($)	*n*	
California	927.10	4,107	14.4
Texas (general)	2,047.00	3,805	15.6
Texas (blind)	3,153.80	736	15.6
New York	3,377.30	607	23.2
Florida	2,679.50	698	14.6
Illinois	2,082.50	300	21.0
Arizona	2,481.60	335	18.3
New Jersey	1,781.80	345	16.2
New Mexico	2,897.30	310	24.2
Colorado	1,323.70	475	19.2
Puerto Rico	3,188.90	3,530	50.3

VR, Vocational rehabilitation.

Results of the present study indicate that Hispanic-origin rehabilitants had relatively high levels of education in contrast to the data cited, which shows the lowest educational attainment of all minority groups is held by Hispanics. How, then, can the rehabilitation system access the underedu-

Table 6. Work Status at Closure for Hispanic-Origin and White Rehabilitants

Work Status	Hispanic Origin		White	
	n	%	*n*	%
Competitive labor market	13,784	79.1	130,737	81.9
Homemaker	1,702	10.0	14,820	9.3
Self-employed	1,165	6.7	3,484	2.2
Sheltered workshop	633	3.6	9,870	6.2
Unpaid family worker	108	0.6	522	0.3
State agency managed	31	0.2	282	0.2
Total	17,423		159,715	

cated Hispanic person with a disability? What part does language play in access to services? Recall that 90% of Hispanics in this country are probably bilingual, speaking both English and Spanish. We also learned that substance abuse and mental illness, along with orthopedic disabilities, rank high among the disabilities reported for Hispanics who applied for services. Are rehabilitation counselors appropriately trained or prepared, either in culture-specific knowledge about Hispanics or about substance abuse (Leal, 1990)? Cultural sensitivity training has been strongly recommended for rehabilitation practitioners working with Hispanics (Rivera and Cespedes, 1983; Arnold, 1983). Yet before such training can be optimally effective and well informed, we need more information on Hispanics' patterns of utilization of vocational rehabilitation services.

Efforts to synthesize and integrate cultural sensitivity into meaningful service delivery requires more awareness and knowledge of the access to and participation in vocational rehabilitation services by people of Hispanic origin. However, Hispanics remain invisible in terms of vocational rehabilitation research, especially in the area of service delivery (Fierro and Leal, 1988). There is a need for research from a national perspective to guide policy planning, needs assessment, and intervention strategy planning. Research should be conducted to identify the predictors of successful rehabilitation for people of Hispanic origin that takes into consideration intragroup and regional heterogeneity. Explanatory analysis is needed to deal with the variation in the range of data from the various regions, in particular, Puerto Rico. There may be special interrelated factors unique to people of Hispanic origin that account for successful outcomes in vocational rehabilitation programs.

Well-planned vocational rehabilitation programs encourage maximum numbers of applications for services. Planning for the vocational rehabilitation of Hispanics for the next decade means planning for a steadily increasing population. Demographically, Hispanics present a profile of social characteristics that have implications for the provision of vocational rehabilitation services both now and in the future. Hispanics are a sociological entity within the state-federal rehabilitation system. The challenge is to identify the extent and nature of their participation in vocational rehabilitation services from a national perspective, while at the same time appreciating and taking into consideration the regional and cultural diversity of this group.

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EC

CLINICAL INTERNSHIP TRAINING PROGRAM IN PSYCHIATRIC VOCATIONAL REHABILITATION

II

Funded by the U.S. Department of Education
Rehabilitation Services Administration

Michelle O. Geckle, M.Ed., CRC
Project Director

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Pittsburgh, PA 15260

FIELD SITE ORIENTATION

Table of Corresponding Instructional Materials

FIELD SITE ORIENTATION

- Training Manual Table of Contents
- Clinic Policy and Procedures
- Specific Policies (Samples)
    - Confidentiality
    - Suicide Prevention
    - Patient Rights
    - Violence Prevention Policy
- Code of Ethics for Rehabilitation Counselors
- Standards of Practice in Psychiatric Rehabilitation
- Standards of Educational and Psychological Testing

INTERNSHIP REQUIREMENTS

- Sample of Internship Description
- Sample of Internship Application Form
- Sample RSA Contract Agreement
- Sample Contract with Field Agency
- Sample Malpractice Insurance Form
- Sample of Daily Log
- Sample Mid-Term and Final Field Work Evaluations

RECORD KEEPING

- Sample Approved Abbreviations List
- SOAP Note Documentation Guidelines
- Sample of Consent for Release of Information
- Sample of Agreement to Contact Patient Relative/Friend
- Sample of Audio-visual Consent Form
- Sample of Initial Evaluation Form
- Samples of Child Protective Law and Criminal History Forms
- Sample of Mental Status Examination

ASSESSMENT AND COUNSELING

- Treatment Planning Manual
- Critical Skills Checklist
- Patient's Assessment of Own Functioning Inventory
- Relative's Assessment of Patient Functioning Inventory
- Psychometric Assessment Manual
- Report Writer's Helper

Sample Case Study including Psychiatric Vocational Rehabilitation Report
Career/Life Plan Form

EDUCATION/TRAINING OPTION

Student Financial Aid Kit
Guide to Writing a PASS

EMPLOYMENT OPTION

Job Club Manual

POST EMPLOYMENT/EDUCATIONAL PLACEMENT FOLLOW ALONG SERVICES

Social Security Administration Manual
Sample Case Study

CASE CLOSURE

Sample Transfer Summary
Sample Discharge Summary

PSYCHIATRIC REHABILITATION AND ASSESSMENT SERVICES

Policy and Procedure

I. POLICY

It is the policy of Western Psychiatric Institute and Clinic of Presbyterian University Hospital (WPIC), through the Department of Psychiatric Rehabilitation and Assessment Services (PRAS), to offer specialized assessments and vocationally-oriented psychiatric rehabilitation services to adolescent and adult patients who are receiving primary psychiatric treatment at Western Psychiatric Institute and Clinic.

In the context of career/or employment concerns, assessment services provided by the department may include: psychoeducational and intellectual evaluation, vocational and career interest, aptitude, and values measurement, and personality and psychopathology measurement. In addition, comprehensive career and vocational rehabilitation services are offered to patients referred to the department. These services may include career and educational counseling, liaison with the Office of Vocational Rehabilitation and community educational and training facilities, job readiness and job seeking skills training, and work adjustment and supportive services.

II. PROCEDURES

A. Referral Process

Patients are referred to the department through formal consultation requests from the various WPIC treatment modules. The written request for services is generally preceded by a phone call from the referring clinician to the Program Coordinator. In the case of outpatients, a telephone call will be made or correspondence sent to establish a first appointment. A letter of confirmation is then sent specifying the date, time, place, name of PRAS clinician and clinic phone number. Upon receipt of the referral, in the case of either inpatients or outpatients, a disposition form is sent to the referral source, indicating the status of the referral.

B. Referral Criteria

The following guidelines are followed for patient referral:

1. Patients who are unemployed and wish to work.

2. Patients who are undesirably employed and wish to upgrade their marketable job skills, change their career or occupational field, or improve their employment status.

3. Patients who have been unable to secure satisfactory employment despite the possession of marketable job skills.

4. Patients who are experiencing difficulty in adjusting to or maintaining employment for desired periods of time.

5. Patients who are uncertain regarding career, employment, or educational/training direction and who desire counseling and assistance with these issues.

6. Patients who have or are currently experiencing significant difficulty in their academic or training program(s).

7. Patients who could benefit from referral and liaison services to the Office of Vocational Rehabilitation and other community rehabilitation, educational/training, or employment agencies.

8. It is required that patients who are referred for and who receive services through PRAS have a WPIC primary clinician for primary psychiatric treatment and care.

C. Assessment Process

A wide variety of standardized psychometric instruments, informal measures, and situational, in-vivo experiences are utilized in psychiatric rehabilitation. The selection of particular instruments and experiences is dependent upon the nature of the patient's problems, goals, and the kind of data needed in order to thoroughly assess needs, deficits, and strengths for any particular patient. When feasible, a comprehensive test battery is used, supplemented by additional testing as indicated by the particular patient performance, referral request, or rehabilitation goal.

Once the evaluation is completed, a consultation report containing a summary of assessment data and recommendations is submitted to the referring party and entered into the patient's medical record.

D. Range of Vocational Rehabilitation Services

A range of services is required in order to facilitate the career development and rehabilitation processes with persons having psychiatric disabilities. Although patients' individual rehabilitation needs are diverse, they tend to cluster around several central themes. Psychiatric Rehabilitation and Assessment Services provides comprehensive services which are organized around these prominent need areas.

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1. Assessment: A comprehensive vocational assessment enables both the patient and the clinician to better understand the patient's interests, aptitudes, cognitive capabilities, academic skill levels, and environmental and interpersonal preferences as related to various career/ educational options. Vocational assessment provides an objective method for identifying a profile of characteristics relevant to career choice. Measurement instruments are tailored according to the kinds of information needed to help a particular individual make realistic choices about career or vocational endeavors. Assessment experiences utilized in the clinic go well beyond that of standardized formal psychoeducational and vocational assessment, however. Functional assessment is critical and may include volunteer experiences, site and informational interviews, credit and leisure-learning courses, and in-house situational assessments on an individual basis.

2. Career counseling and supportive services: Many patients referred for services have had significant difficulty in identifying and implementing or completing realistic vocational/ educational plans. Counseling services are geared toward interests, abilities, preferences, tolerance for specific stressors and available resources and supports. Significant attention is given to the patient's concerns and anxieties about adjusting to school/training or employment and the prospect of increasingly independent functioning. The use of the Service's Employment, Education and Career Resource Library provides a data base which enables clinicians and patients to have access to current information regarding employment trends, detailed descriptions of careers and requisite abilities, as well as courses of study available at local colleges, vocational schools, and rehabilitation facilities.

3. Job seeking skills training, job development, placement, and supportive services: Many patients have been unable to acquire employment despite the possession of marketable skills. Job seeking skills training, conducted on an individual or group basis, prepares individuals to be able to thoroughly complete employment applications, generate and follow-up on job leads, prepare resumes, organize employment searches, and present themselves well in employment interviews. Attention is specifically paid to handling interview questions regarding disrupted work histories, frequent job changes and employment accommodations. Extensive linkages and case management services are provided in utilizing various community agencies and resources which provide related employment and job preparedness services. Individualized job development, placement, and advocacy with employers are offered as appropriate.

4. Work adjustment counseling and long-term supportive services: Inability to maintain employment, in many cases, is related to impaired interpersonal skills, inability to cope with specific and/or more generalized work-related stressors, and difficulty adjusting to the impact of earned income on various consumer benefits. Work adjustment counseling includes training in social and coping skills with an emphasis upon adapting to stressors in the work environment, job analysis and modification, employer advocacy and intervention, and assistance in managing leisure time and finances. Flexible and long-term supportive counseling is provided for all patients for as long as it is beneficial and indicated.

Revised: 09/9/93

University of Pittsburgh
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

MEMORANDUM

TO: All WPIC Clinicians

FROM: Lynda J. Katz, Ph.D., Program Director
Michelle Geckle, M.Ed., Program Coordinator

DATE: 8-3-93

RE: Psychiatric Rehabilitation and Assessment Services Department

We are pleased to announce the opening on September 1, 1993 of the Psychiatric Rehabilitation and Assessment Services (PRAS). The Department under the direction of Lynda J. Katz, Ph.D., PRAS, will offer specialized assessments and comprehensive psychiatric-vocational rehabilitation services to WPIC patients under the care of a WPIC primary clinician and physician of record.

Psychiatric Rehabilitation services offered will include the following:

1. Vocational, intellectual, and psychoeducational assessments, including personality assessment if indicated.
2. Career and educational exploration, counseling, and planning, including individual, group, and career resource library services.
3. Referral and liaison services with community educational, rehabilitation, employment, and benefits agencies/service providers, including the Office of Vocational Rehabilitation, colleges, trade and technical schools, the Social Security Administration, and the Department of Public Welfare.
4. Pre-Employment services, including individualized resume, interview, and job search preparation, employer advocacy, and job development and placement services.
5. Post-Employment/Supportive Employment services, including work adjustment and maintenance counseling, crisis intervention, benefits analysis and management, job analysis and modification, employer intervention assistance.

3811 O'HARA STREET, PITTSBURGH, PA 15213-2593

The following referral guidelines are offered for use by WPIC primary clinicians and physicians:

1. Individuals who are unemployed and wish to work.

2. Individuals who are undesirably employed and wish to upgrade their marketable job skills, change their career or occupational field, or improve their employment status.

3. Individuals who are uncertain regarding career, employment, or educational/training direction and who desire counseling and assistance with these issues.

4. Individuals who could benefit from referral and liaison services to the Office of Vocational Rehabilitation and other community rehabilitation, educational/training, or employment agencies.

5. Individuals who have been unable to secure employment despite the possession of marketable job skills.

6. Individuals who are experiencing difficulty in adjusting to or maintaining employment for desired periods of time.

The PRAS Department will be located in Suite 204 in the Iroquois Building at the corner of Forbes and Meyran Avenues. Referrals may be made by consultation with the **Program Coordinator, Ms. Michelle Geckle, M.Ed, CRC at 624-2842**, or in writing utilizing the Consultation Request Forms of the former Neuropsychological Assessment and Rehabilitation Services Department of WPIC, supplies of which are available in the PRAS Department. Please feel free to direct any questions or requests for further information to Ms. Geckle.

cc: Diane Holder

UNIVERSITY OF PITTSBURGH

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

NEUROPSYCHOLOGICAL ASSESSMENT AND REHABILITATION SERVICES (NARS) CONSULTATION REQUEST FORM

IMPRINT PLATE

NAME HOSP. NUMBER AGE SEX

ADDRESS PHONE

REFERRED BY DATE CLINIC EXTENSION

REASON FOR REQUEST:

WORKING DIAGNOSIS(ES):

EDUCATIONAL/VOCATIONAL BACKGROUND:

CURRENT MEDICATIONS:

REMARKS, PRECAUTIONS, SPECIAL REQUESTS, ETC.:

COMPLETE FOR ASSESSMENT REFERRALS ONLY:

EVIDENCE OF BRAIN DYSFUNCTION

History:

Positive Physical Findings:

Specific Findings (Please specify and give dates)

	Nor	Abn	Not Ord	Ord Not Done
EEG	☐	☐	☐	☐
CT Scan	☐	☐	☐	☐
Sleep Study	☐	☐	☐	☐

Previous Neuropsychological Testing

Mental Status Exam

Other Tests (e.g., Angiogram, Brain Scan) or Neuropsychological Procedures:

ITEM #807100

WHITE - CHART COPY CANARY - NARS COPY

PATIENT'S RIGHTS: CONFIDENTIALITY

Policy and Procedure

A. Regulations pursuant to the Mental Health Procedures Act provide that (See section 5100.31).

> Persons seeking or receiving services from a mental health facility are entitled to do so with the expectation that information about them will be treated with respect and confidentiality by those providing services. Confidentiality between providers of services and their clients is necessary to develop the trust and confidence important for therapeutic intervention. While full confidentiality cannot be guaranteed to everyone as a result of Federal and State statutes which require disclosure of information for specific purposes, it remains incumbent upon service providers to inform each current client/patient of the specific limits upon confidentiality which affect his or her treatment when these limits become applicable. When facilities are required by Federal or State statute or by order of a court to release information regarding a discharged patient, a good faith effort shall be made to notify the person by certified mail to the last known address.

B. The regulations also provide that confidentiality is a patient right.

C. Thus, confidentiality is a manifestation of professionalism in the delivery of mental health care. Physicians, psychologists, nurses, social service personnel, psychiatric assistants, clerical personnel, and indeed, any and all persons who work at WPIC are bound, by virtue of their being employed here and by virtue of the type of job that they do, to insure that information learned about patients remains confidential. This means that the information that the patient relates to the hospital about his/her problems, or information about the patient that is gathered from his/her friends and family members, is necessary for good patient care. It is the patient's rightful expectation that the material he/she relates will not become available to persons who are not responsible for his/her care. Information that is important to good patient care may be embarrassing or of a very personal nature which the patient does not want others to know. Confidentiality as a general principle applies to the type of information the patients may relate about themselves by word of mouth, other communications that patients may write, and also the patients' records. The issue of whether or not a person even is or is not a psychiatric patient at the Hospital is itself "confidential."

D. Patients, in the type of treatment milieu present at WPIC, may attempt to swear a staff member or an employee to confidentiality about their personal feelings of life history. Patients may sometimes say to staff that they want to relate some piece of information which they want shared with no one else. To make such an agreement with a patient, however appealing or flattering to an individual staff member or employee, is however often not in the best interests of patient care. For example, the staff member or employee is in a difficult bind if the patient talks about feelings of suicide only to that staff member. It is not an abuse of confidentiality for information given by patients to be shared with other staff members if this information is relevant to their care. As a general rule then, if a hospitalized patient asks not to have information discussed with other staff, try to indicate that this type of contract or agreement is impossible, that such information must be disclosed to other staff responsible for their care, but no one else.

E. Please consult WPIC Legal Counsel (647-8480), or Law and Psychiatry (624-2161) if you have any questions or desire assistance.

Revised: 3/83
3/86
Reviewed: 2/88
Revised: 2/89
3/90
Reviewed: 2/91
2/92

SUICIDE PREVENTION

Policy and Procedure

I. POLICY

It is the policy of Western Psychiatric Institute and Clinic to take reasonable precautions to minimize the risk of suicide or other self-destructive behavior. The guidelines outlined below are based on the recognition that suicidal behavior is not pathognomonic of any specific psychiatric syndrome. It is seen most frequently in persons exhibiting depressive symptoms, regardless of whether such symptoms occur in the context of "primary" affective disorder, or, as is often the case, are "secondary" in the sense that they occur in association with some other psychiatric illness.

II. PROCEDURE

A. Evaluation of Suicide Risk

Clinicians interviewing patients in the Diagnostic & Evaluation Center should specifically inquire about past and current history of suicide attempts, preoccupations about suicide, availability of weapons, drug abuse, changes in current sleep and activity patterns, family history of depression and suicide, and mental status examination. Each patient is then seen by a psychiatrist, who, together with the clinician, evaluates the patient's suicidal risk, makes a preliminary diagnosis and disposition regarding the treatment recommendations made for the patient as well as the setting (inpatient or outpatient). Whenever possible, collateral information is obtained from the family or significant others, to further assess the risk of suicide.

The following factors, culled from the literature, may be helpful in evaluating suicidal risk.

1. Marital Status
2. Physical Illness
3. Depressive Disorder
4. Insomnia
5. Gender
6. Schizophrenia
7. Alcohol and Drug Abuse
8. Previous Suicide Attempts
9. Lethality of Previous Suicide Attempts

10. Living Arrangements
11. Age
12. Religion
13. Race
14. Family History of Suicide
15. Recent Loss
16. Employment Status

Evaluation of suicidal risk continues throughout the hospitalization. Clinical information relevant to suicide which was not obtained in the Diagnostic & Evaluation Center will be obtained as soon as possible upon admission to an inpatient service. Each patient's suicide risk is carefully monitored; every effort is made on inpatient services to establish individual contact with each new patient as quickly as possible.

Patients who are referred from the Evaluation Center to an outpatient clinic receive an initial clinic evaluation and ongoing evaluation which includes a reassessment of the patient's suicidal risk. Any patient receiving care in an outpatient clinic who becomes an unacceptable suicidal risk should be considered for inpatient admission.

B. Therapeutic Approaches to Suicide Prevention

1. Listen carefully to what the patient says about his suicidal attempt or thoughts. An understanding of the patient's view of the situation, style of coping with immediate and chronic life along with his complete medical and psychiatric history is necessary before a relevant treatment plan can be formulated.

2. Provide the patient with a sense of external controls and an atmosphere of safety. Contributing to this sense of control, is that staff communicate among themselves about the patient's suicidal ideation and plans, the patient is informed of the lack of absolute confidentiality regarding this issue.

3. Search - The patient, his belongings, and the inpatient unit must be free from harmful objects. The patient is searched immediately upon admission to the unit and thereafter as needed. Razor blades, medications, glass objects, scissors, knives, etc., are removed from patient access. Objects such as razor blades will be used only under staff supervision. Belts, neckties, necklaces, jewelry, keys and shoelaces are routinely removed from the patient who would not be considered safe having these items. Safety measures are carried out in a respectful, informative style so that the staff minimizes making the patient feel more incompetent and inadequate, feelings with which he may already be struggling. It may be necessary for the patient to have a private room to maintain these precautions.

   The patient's visitors are greeted by the staff and assessed so that potentially harmful gifts are not given to the patient (glass, scissors, certain foods for patients on a Parnate diet, etc.).

4. Observation
   A patient who is thought to be a high risk for suicide is not alone on an inpatient unit and is on one of the following types of protective intervention.

   CO connotes "Constant or Continuous Observation" by staff. The patient is within the view of a staff member at all times. The patient cannot lock himself in his room, the bathroom, or sit off from all human contact. The patient may be involved in a group, sitting alone in the patient lounge or involved any other activity where a staff member can [illegible]nuously observe him.

   SCO connotes "Special Constant Observation." A staff member constantly observes and interacts individually with the patient within arm's distance. SCO should only be ordered in rare or exceptional circumstances. If this level of observation is needed, a physician's order with supporting documentation is required.

   Either of the above levels of observation may be ordered by a physician or initiated by the nursing staff. Should the nursing staff initiate either level of observation, rationale for this decision is recorded in the medical record and reviewed by the patient's physician as soon as possible, and always within a period of two hours. When a physician orders any of the above, the patient may only be removed from level of observation ordered by a written order by the physician changing the patient's status. Should nursing staff indicate the observation status, a physician still must assess the patient and write an order when the status can be reduced.

   The patient's behavior on the unit is carefully observed and always recorded in the medical record (e.g., how the patient interacts with others, including family and friends, what the patient talks about, how he eats, sleeps and his motor activity).

C. Management

1. Patients who are high risk for suicide should eat their meals on the unit or be accompanied by a staff member to the patients' dining room. These patients should not leave the unit for any reason without staff accompaniment (example: meals, diagnostic studies, etc.).

2. If patients remain on CO or SCO longer than 24 hours, a reevaluation should be done by both the physician of record and unit staff to determine if this status should be continued.

3. Suicidal patients who elope from the hospital under the 201, 302, 303 admission status and are still considered a serious suicidal risk will be returned to the hospital as soon as possible. Patients on a voluntary (201) who need to be forcibly returned to the hospital should be converted to a 302 status if they fit the commitment criteria. The police will be notified; an initial investigation report completed and the appropriate Program Director and Hospital Administrator called (See Elopement Policy and Procedure).

4/84
Revised: 3/86
3/88
2/89
1/90
1/91
2/92

RIGHTS AND RESPONSIBILITIES OF AMBULATORY CARE PATIENTS

Policy and Procedures

I. POLICY

It is the policy of Western Psychiatric Institute and Clinic to recognize the basic rights and responsibilities of patients in the ambulatory care setting and to set forth these rights and responsibilities for staff and patient information and implementation. The following statements pertain to the Rights and Responsibilities of outpatients.

A. Patient Rights

1. Patients shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sex, or sources of payment for care.
2. Patients have the right to considerate, respectful care at all times and under all circumstances, with recognition of their personal dignity.
3. Patients have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Patients have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Pennsylvania Law.
5. Patients have the right to expect reasonable safety insofar as the hospital practices and environment are concerned.
6. Patients have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care.
7. Patients have the right to obtain, from the practitioners responsible for coordinating their care, complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis.
8. When patients do not speak or understand the predominant language of the community, they will have access to an interpreter when possible.

9. Patients have the right to reasonably informed participation in decisions involving their health care. To the degree possible, this should be based on a clear, concise explanation of their condition. The patient will not be subjected to any procedure without his/her voluntary, competent, and informed consent or that of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

10. Patients shall have the right to refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his legally authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.

11. Regardless of the source of payment for their care, the patients have the right to request and receive an itemized and detailed explanation of their total bill for services rendered in the hospital. The patients have the right to timely notice prior to termination of their eligibility for reimbursement by any third-party payer for the cost of their care.

12. Patients have the right to be informed of the hospital rules and regulations applicable to their conduct as patients. Patients are entitled to information about the hospital's mechanism for the initiation, review, and resolution of patient complaints.

Pennsylvania Department of Public Welfare Regulations require that each facility have a grievance and appeal system in effect to insure that the patient rights enunciated in the regulations are safeguarded and disputes resulting therefrom are resolved promptly and fairly. At WPIC this process is assured by the Patient Rights Coordinator. The following individual can be contacted:

Katharine Luther, M.P.M.
5th Floor-ERC
Phone: 624-1993

13. Because WPIC is a teaching hospital, some patients are involved in clinical research projects and their treatment is monitored in special ways. Thus, it is possible that assessment material and intake information relating to their care will be reviewed by approved researchers for purposes of identifying them as potential subjects in a WPIC research program. Whether or not they decide to participate in a research project is, of course, voluntary.

____________Patient Agrees   ____________Patient Objects

1230

B. Patient Responsibilities

1. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Patients are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.

2. Patients are responsible for following their treatment plan as recommended by the practitioner primarily responsible for their care. Patients are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.

3. Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions.

4. Patients are responsible for assuring that the financial obligations of their health care are fulfilled as promptly as possible.

5. Patients are responsible for being considerate of the rights of other patients and hospital personnel, and for being respectful of the property of other persons and of the hospital.

6. Patients are responsible for complying with hospital policies and directives of appropriate hospital personnel.

II. PROCEDURES

A copy of the Rights and Responsibilities of Ambulatory Care Patients Bill of Rights (Attachment) is available in each ambulatory care setting within WPIC. In addition, ambulatory care patients will be given a copy of the Bill of Rights at the time of the review and will sign the initial treatment plan.

3/86	
Revised:	5/86
Reviewed:	5/88
	3/89
	3/90
Revised:	2/91
Reviewed:	2/92

Carol M. Anderson

Carol M. Anderson, Ph.D.
Adminstrator

L Roth

Loren Roth, M.D., M.P.H.
Chief of Clinical Services

5-15-79

Date

PATIENT'S RIGHTS:
GRIEVANCE AND APPEAL PROCEDURES

Policy & Procedure

I. POLICY

Pennsylvania Department of Public Welfare Regulations 7100.1 et seq (pursuant to the authority of 112 of the Mental Health Procedures Act) require that each facility have a grievance and appeal system in effect. The purpose of the system is to insure that the patient rights enunciated in the regulations are safeguarded and disputes resulting therefrom are resolved promptly and fairly. Patients and family members or, where appropriate, legal guardian are to be informed of the system and they are to be encouraged to utilize it when individual informal methods of resolving complaints are unsuccessful. The following procedures comprise the grievance and appeal system at Western Psychiatric Institute and Clinic.

A. The Patient Rights Coordinator

1. The Executive Committee shall appoint a Patient Rights Coordinator.
2. The Patient Rights Coordinator shall be a member of the Quality Assurance and Risk Management Committee.
3. Duties of the Patient Rights Coordinator

    (1) The Patient Rights Coordinator shall develop and implement procedures which assure that each patient, or family, or legal guardian of Western Psychiatric Institute and Clinic is advised about the Patient Grievance and Appeal Procedures.

    (2) The Patient Rights Coordinator shall communicate, when indicated, with a patient, family, legal guardian, BSU, or representative to discuss problems concerning patient rights or the quality of services and treatment provided to the patient or family. When a problem exists, the Patient Rights Coordinator shall work with the patient, family or legal guardian, and Western Psychiatric Institute and Clinic in trying to reach a solution which is acceptable to the patient, family, or legal guardian and Western Psychiatric Institute and Clinic.

    (3) In accordance with the requirements of the Federal Patient Self Determination Act and WPIC Policy and Procedure concerning Advance Directives, upon referral by the patient's attending physician, the WPIC Patient Rights Coordinator shall provide consultation and, where appropriate, related patient information materials pursuant to advance directives and/or refusal of life sustaining treatments to patients and/or family members/concerned others/legal guardian(s).

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II. PROCEDURE

A. Informal Complaint Procedure

The Patient Rights Coordinator shall initially respond to patient/family/legal guardian complaints by utilizing informal methods of attempting to resolve them.

B. Formal Complaint Procedure*

1. When the Patient Rights Coordinator is unable to informally resolve a complaint, then the Patient Rights Coordinator shall assist the patient, family, or legal guardian in presenting the complaint as soon as possible to the treatment team leader or other appropriate person. The patient, family, or legal guardian shall have the right to the assistance of an independent person and witnesses in presenting his or her complaint.

2. The treatment team leader, administrative supervisor or their designees receiving the complaint shall investigate the complaint and make every effort to resolve it. Based upon this investigation, a decision shall be rendered in writing as soon as possible but within 48 hours after the filing of the complaint. Complaints shall be decided by persons not directly involved in the circumstances leading to the grievance.

3. The patient, family, or legal guardian shall be given a copy of the complaint and final decision and a copy shall be filed.

C. Appeal Process*

1. Any patient, family, or legal guardian or those helping him or her, may appeal the grievance decision within 10 working days of the decision. The appeal will be filed with the Patient Rights Coordinator who shall notify the Hospital Administrator and the Chief of Clinical Services/Director of the Law and Psychiatry Program.

2. The Patient Rights Coordinator shall coordinate the establishment and meeting of a committee to fairly hear the complaint. The committee shall be composed of the Associate Director or designee, the Program Chief of Clinical Services or physician designee.

3. The patient, family, or legal guardian shall be given prompt notice of the date set for the appeal and shall be informed of his or her right to be represented by counsel.

*In the case of a grievance/appeal made by a patient who is 14 to 18 years of age, consideration should be given to discussing the complaint with the patient's family or legal guardian. This policy shall be in conformity with WPIC policy and state law regarding confidentiality of patient information. If the patient and family or legal guardian disagree with the filing of a grievance or appeal, WPIC Legal Counsel and Law and Psychiatry should be consulted.

4. Hearings shall be informal without strict adherence to the rules of evidence. Sufficient records of the hearing shall be made.

5. The opinion of the appeal committee shall be given to the facility Director who shall make the final decision, a copy of which shall be provided to the patient, family, or legal guardian.

D. Additional Appeal - Outside Agencies

1. If the patient, family, or legal guardian is not satisfied with the decision of the Appeals Committee, or elects to utilize an agency external to WPIC for purposes of presenting the grievance, then the Patient Rights Coordinator shall refer the patient to the following sources in writing.

a. Allegheny County MH/MR/DNA Program
Wood Street Commons
304 Wood Street
Pittsburgh, PA 15222

b. Bureau of Civil Rights Compliance
Department of Public Welfare
Room 412, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

c. Office for Civil Rights
U.S. Department of Health and Human Services
Region III, P.O. Box 13716
Philadelphia, PA 19107

d. Pennsylvania Human Relations Commission
101 South Second Street
Suite 300
Harrisburg, PA 17105

e. Bureau of Civil Rights Compliance
Department of Public Welfare - Western Field Office
702 State Office Building
300 Liberty Avenue
Pittsburgh, PA 15222

Patient complaints of discrimination may also be filed with any other Human Rights Agency having jurisdiction.

Reviewed:	4/84	Revised:	2/91
	4/86		7/91
	3/88		2/92
	3/89		
	3/90		

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Date

VIOLENT PATIENTS: MANAGEMENT AND CONTROL
VIOLENCE PREVENTION POLICY

I. POLICY

It is the policy of Western Psychiatric Institute and Clinic to take all possible precautions to minimize the chance of violence or other behavior resulting in harm to others.

The therapeutic control of violence is an occupational hazard among all mental health workers. For purposes of this policy statement "violence" is defined as hitting or striking behavior accomplished by a patient towards another patient or towards staff, or accomplished destruction of property. Included here is a wide spectrum of behavior ranging from the temper tantrum in the child to the barroom brawl in the adult.

Not all patients who threaten violence accomplish it. The "potentially violent" patient is defined as the patient who makes verbal threats to harm, who appears or acts in an angry manner, who speaks loudly and in an accusatory or threatening manner, the patient who by his demeanor and his actions causes staff and other patients to fear him. Most potentially violent or threatening patients do not become violent. Such potentially violent patients must be handled in a manner, however, so as to minimize the chance of actual violence.

The Institute's policies on violence can be more specifically described by conceptualizing types of violent patients:

A) Criminal Violence plus Psychiatric Illness - If a patient is determined to have charges pending, or to be liable to charges if not admitted, the decision whether to admit or to send the patient to the mental health unit of the County Jail must be made. If the patient remains in the hospital for more than 48 hours, this is a tacit statement that staff considers this patient's behavior to be consistent with behavior found in a psychiatric setting. Priority must be given to evaluation of this type of patient because of the potential effect of this patient in the safety of both other patients and staff.

B) Characterologic Violence plus Psychiatric Illness - There are some patients who will exhibit violent behavior whether or not they are acutely ill. The clue here is a significant Axis I and Axis II diagnosis (as per D.S.M. III-R). Institute policy regarding this type of patient is that hospitalization will be for a short-term treatment of the Axis I diagnosis after which time the patient will be discharged. Since violence is part of baseline behavior in these individuals, it is not considered to be reason for admission, or extended hospitalization (although this behavior does present clinical management issues).

C) Violence associated with Mental Retardation plus Psychiatric Illness - Like those patients with characterologic type violence, these patients are admitted only for treatment of their psychiatric illness. If a patient is already hospitalized at a long-term treatment facility, preference would be for treating the person there with consultation with WPIC faculty and staff.

D) Violent Behavior as a Symptom of Psychiatric Illness - Those patients whose violence appears as a symptom of an acute psychiatric illness (e.g., psychotic patient responding to command auditory hallucinations) present no conflict as to the appropriateness for hospitalization and/or other treatment at WPIC.

E) Criminal Violence with no Psychiatric Illness Evident - The individual who is under arrest for criminal activity of a violent nature is considered to be more appropriate for evaluation in a penal setting.

In short, WPIC policies vary according to the category of violence into which a particular patient falls. This indicates that assessment is a critical variable in the decision to hospitalize, to predict violence, and to help strive towards more realistic treatment and discharge planning.

II. ASSESSMENT OF RISK OF VIOLENCE

Psychiatric clinicians make daily decisions concerning the assessment, prevention, and management of violent behavior. The relevant literature reveals a number of correlations between violence and clinically related variables. However, most of the studies on outcomes of predictions have shown the accuracy to be about the same as a "flip-of-a-coin." It's important to note that most of the prediction studies have addressed long-term decisions usually concerning courtroom findings of dangerousness. Recent research on the prediction of dangerousness, on a short-term basis, offers tentative data toward supporting the notion that clinicians can, with greater accuracy, predict dangerousness when the time period of prediction is reduced. For example, in emergency civil commitments, the time period between point of prediction and validation period of the specific behavior is short (3-5 days). Basically, this research lends more validity to the clinical variables that have been correlated with violence.

Prediction of who will be violent or "dangerous" remains a difficult business. Persons who are in the midst of being violent; i.e., striking other persons or actually breaking up property, are therefore the only patients who are properly labelled as violent.

The most reliable predictors of future violence are:

A. Recent history of already accomplished violence; i.e., the patient has already been violent in the previous hours to days.

B. There is a history of previous violence prior to the immediate time period of management.

C. The patient is a young male, for example, between the ages of 15 and 35.

D. Drug and Alcohol Abuse or Dependence

E. If the patient's prior history is well known, other "predictors" may be at least considered. For example, it may be useful to know that the patient has struck out in the past against others when taunted, when challenged as to his masculinity, when he has recently experienced a loss, when his reality testing has been quite disturbed; i.e., he has been psychotic or has been experiencing imperative auditory hallucinations when he has been intoxicated with alcohol or other substances. The present circumstances should be compared with the past regarding their similarity in provoking violence.

The following clinical variables have been correlated with violent behavior and should be viewed as contributing factors; i.e., with each variable evident, the risk of violence may increase. Also, these variables should be thought of as "cutting across" diagnostic categories.

A. Assessment of the Patient

1. Personality Factors
    - a. General hostility
    - b. Chronic anger
    - c. Motivation for aggression
    - d. Poor impulse control
    - e. Individual beliefs and/or lack of "taboos" against engaging in violent behavior

2. Substance Abuse
   The APA Task Force #8 (1974) described alcohol as a common contributing factor to violence. Amphetamines, PCP, and cocaine also frequently contribute to violence.

3. History of Suicide Attempts and Current Homicidal/Suicidal Ideation or Intentions
   Some studies have demonstrated a strong correlation between suicidal and violent behavior.

4. History of Violent Behavior
   Here it is essential to know the circumstances preceding past violent behavior. For example, has a patient struck out when he perceived a challenge to his masculinity, when he has been hearing voices, has experienced a loss, when using or abusing alcohol and/or drugs, etc.

5. Previous History of Verbally Abusive Behavior, Temper Tantrums, Impulsivity and Other Repetitive Antisocial Behavior
   A large number of violent patients have histories of emotional deprivation, demonstrate impulsiveness and have poor control of aggressive urges. Violent patients are frightened of their own hostile urges and seek help in preventing a loss of control. The patient's use of aggressive behavior can be the patient's way of dealing with an unbearable sense of fragility and helplessness. Adding to helplessness and deprivation is intense fears and hurt feelings.

6. History of Criminal Arrests
   Legal histories have been thought of as an important variable in predicting dangerousness.

7. Delusions (Paranoid especially)

Patients who are frightened that someone else is out to hurt them in some way may assault a person who becomes part of their delusional material and who they perceive is going to hurt, poison, or otherwise attack them. Such assaultive behavior would be viewed by the patient as self-protective. A patient who has delusional ideas, that, if true, would lead a "normal" person to behave destructively, requires close observation.

8. Imperative Auditory Hallucinations

Patients who hear voices telling them to hurt someone are in danger of following the instructions of such voices which may include assaults.

9. Projective Thinking and Feeling of Self as a Pivotal Point of Events

10. Suspiciousness and Viewing World as a Hostile Place

Hypervigilance is a clinical sign.

11. Grandiosity

12. Fear of Loss of Autonomy and Control

A core dynamic theme seen in violent patients is helplessness. Patients may also defend against passivity, helplessness and underlying homosexual stirrings (Homosexual Panic) by adopting a hypermasculine stance whereby they become aggressive as a way of preserving their masculinity.

13. Sleep Deprivation

Significant loss of sleep lowers the patient's level of consciousness, increases the patient's capacity to distort perception and increases irritability and limits control of impulses.

14. Cerebral Dysfunction

Certain types of brain dysfunction appear to contribute to assaultive behavior. Examples include temporal lobe epilepsy, minimal brain damage and retardation. Although a past history of violent behavior, with associated electroencephalographic abnormalities, may involve the temporal lobe, violence as a direct seizure manifestation is very rare. Also, EEG recordings may confirm a diagnosis or reveal nothing. In those patients who are violent and demonstrated to show some form of epilepsy, attention should be paid to environmental and social factors which may play a role in the genesis of the aggressive behavior.

15. Medical and Other Organic Factors

Violence originating from some of these factors is frequently of a primitive sort; e.g. reports of biting or scratching. The following factors should be entertained especially in patients demonstrating behavior quite out of character with pre-morbid functioning.

a. Tumors of the limbic system
b. Certain encephalitic disorders
c. Metabolic condition such as hypoglycemia

d. Normal pressure hydrocephalus with dementia

e. Pre-menstrual tension in women has been noted to be a contributing factor in criminal and aggressive behaviors.

B. Provocative Situations - Particularly on the Inpatient Unit

1. The Composition of the Nursing Staff
A study by Levy and Hartocollis comparing two inpatient units, one staffed with female nurses and aides and one unit with a more traditional nurse and male aide staffing pattern.

The unit comprised of female staff had no incidents of other-directed violence, but the traditionally staffed unit had 13 violent incidents. The authors state that when male aides are used to control violence, the probability of violence is increased because the "male aide's formal or informal role as masculine authority is based on the intent to do violence." "This intent is potentiated by female nursing personnel who expect the male aide to confront troublesome patients for them." The use of professional nurses and some female aides may keep the unit's focus on interpersonal ways of handling aggression and keep the incidence of assaultive behavior in a psychiatric unit to a minimum.

2. The Use of Physical Activities to Help Patients Express Aggressive Urges
Such cathartic aggressive behavior may seem therapeutic but in a permissive setting may maintain the behavior at its original level or increase it. The use of physical activities (basketball, etc.) must be subordinate to the therapeutic focus of having patients develop cognitive abilities to understand the causes and events that precede violent behavior. Verbal work takes precedence over physical actions.

3. Patient Experiencing Verbal Insults or Humiliation from Staff in the Form of Verbal Threats or Attempts through Bantering or Ridicule to Disapprove of the Patient's Behavior
Insults or embarrassing situations provoke aggression in patients who are prone to be aggressive and in normally non-aggressive persons.

4. Staff Fear of the Patient will Exacerbate the Patient's Potential for Violence
Patients who are frightened of losing control of themselves and who are depending on staff to assist with controls will not be reassured by a frightened staff. Staff need to spend time understanding their own feelings and getting mastery over themselves before they can be helpful to the patient. Staff need to understand what the patient is experiencing, and their own responses to the patient; working together, the staff need to develop more comfortable and reassuring ways to respond to each violent patient.

C. Interstaff Communications

Interstaff issues and dynamics can influence the occurrence of various behaviors on the inpatient psychiatric unit. The "Therapeutic Community" and "Hospital Milieu" literature contains many descriptions of how certain staff conflicts are acted out by inpatients.

Violent behavior can many times be prevented or lessened by staff identification of problematic staff-to-staff and patient-to-staff communications. Some patients are more sensitive than others to acting out staff conflict. For example, strained communications between staff due to a split in leadership, on the floor between Medical Director and Nurse Clinical Manager, may make a tense environment among staff due to resulting splitting down through the ranks. This may lead to a tense and bitter emotional milieu. The anxieties of individual patients then increases. Furthermore, the anxieties that arise in such situations are notably more evident on a closed or intermittently closed unit, since patients feel that staff are unaware of potential danger. The patient who is a higher risk for violence (based on the factors we discussed earlier) may be the "scapegoat" who is "sacrificed" by the patient/staff group and acts out violently.

There are many ways in which staff communications may become distorted and/or problematic. Splits between senior-junior staff, between disciplines, between male-female, and between black-white are types that have been frequently observed. Inpatient group therapy sessions and community meetings can be rich sources of data on these distorted behavior patterns among staff and patients.

Staff sensitivity sessions, educational inservices, and community discussion of perceived problems are all possible ways of identifying conflicts, and then taking the appropriate action to help with the prevention of violence.

III. CLINICAL MANAGEMENT

A. The guiding principle is to help the patient talk out feelings rather than act them out physically. Helping the patient change from a physical style of responding to his feelings to a more cognitive and verbal style pervades all treatment with such patients.

B. When the patient is clearly angry or verbally abusive, staff must acknowledge the patient's angry feelings and behavior. Focusing on the process of the interaction rather than only the content is an important shift in emphasis during such situations.

C. The patient's anger may be diluted before physical aggression takes place. At times the one-to-one verbal interaction with staff is the intervention of choice; at other times using a structured, well run patient-staff group meeting can be effective in diluting anger and reassuring the patient that he will not be allowed to lose control. Well timed use of humor by those staff gifted with a tasteful sense of humor is quite effective in diluting anger. If the patient is prevented from losing control, his self-respect and dignity will have been maintained.

D. Individual or group work with such patients acknowledges their feelings and helps them to express anger in more socially acceptable and controlled ways; this style of limit setting is experienced as reassuring to most patients.

E. The verbal and cognitive work with such patients involves helping the patient to learn to understand and to predict in advance their own violent impulses. Only then does the patient have mastery over when to get help to prevent loss of control.

F. When the patient is about to be violent or has a violent outburst:

1. Don't walk away from the patient.

2. Acknowledge the patient's feelings and behavior. The staff member should use silence during a verbal outburst until it is over to avoid escalating the behavior. Here the use of "underwhelming force" is useful. Talking alone with one mental health professional about what the patient is feeling and about what has happened may be calming. The staff member and patient should be able to perceive the safety of the interaction because other staff are available at a distance.

3. If medication is indicated for the patient, then give the medication with the message that the medication will help him control himself. Violent or suspicious patients may be fearful that you are trying to "snow" them and may refuse medication. The use of medication is to be carefully explained. If the patient refuses medication, give the patient some "elbow room." A dignified 10 minute time period for the patient to take medication on his own is preferable. If medication must be given against the patient's will, then prepare IM medication with staff prepared to use "overwhelming force," if necessary. In general, if a patient is violent as a consequence of delusions or hallucinations, an antipsychotic is used.

4. "Overwhelming force" may be used to give medication. Walking a patient to a quiet room or to seclusion may be needed. Patients who are violent are often reacting to feelings of helplessness and loss of control. It is provocative rather than reassuring to the patient if, from his perspective, he perceives there is going to be a battle to control his behavior. It is not necessary that the patient be physically restrained or overpowered; sometimes merely approaching the patient with a clear show of force, plus making a statement by one of the group that his behavior must cease, is sufficient to cause the behavior to cease. The patient must not be touched unless there is sufficient staff available to control the patient.

5. The use of a quiet room may be used as a temporary and nonpunitive way of helping the patient regain control of himself before discussing his violent feelings and behaviors. It is important to understand that isolation by use of a quiet room or seclusion is temporary. Placing the patient in isolation will not help the patient learn about his experience during the critical time when learning is important. Isolation should be as brief as possible and be followed by the psychological work

necessary for the patient (also see Seclusion Policy and Procedures). Leather restraints or wet packs may be indicated when the patient cannot be adequately protected from self injury in seclusion. (See Leather Restraint Policy and Procedure and Cold Wet Pack, Dry Sheet Pack Policy and Procedure.

6. The staff member most appropriate to be with the patient during this time of fear and violence is the one who has the best rapport with the patient--not necessarily the one with the most authority, rank, etc. Interpersonal understanding and intervention with such patients requires rapport and cannot be legislated by a person in authority who has no rapport with the patient in question.

7. Other patients should be accompanied away from the area where the violent patient is being controlled.

8. Post-violence analysis conferences can and should be called by anyone involved in the incident to determine how and what was well done, what could have been better handled, and how can future incidents be predicted and more important, prevented.

IV. INVOLUNTARY TREATMENT OF THE VIOLENT PATIENT

The patient on a 201 voluntary or 302 emergency detention, 303 commitment or 304 commitment status who has been recently violent, who is "dangerous" to others, may be treated with psychotropic medications, either orally or intramuscularly, even against his will and over his objection. Accompanying the treatment of such patients must be adequate documentation in the chart describing in some detail, the nature of the patient's previous violence and the rationale for his involuntary treatment, and that lesser steps have previously been tried or considered, and have been found unsuccessful or not indicated.

V. PREVENTION OF VIOLENCE

There is a wide range of management techniques available to prevent violence. These are referred to in the WPIC Seclusion Policy and Procedures. These include:

A. Assessment and clinical management of the patient as previously described.

B. Review of psychopharmacological management.

C. Use of the patient's hospital room as a "quiet room."

D. Assigning staff to spend time individually with patient (CO or SCO).

E. Use of cold wet packs.

F. Use of leather restraints (See Leather Restraints policy).

G. Any or all of these techniques may be useful in preventing violence:

1. Among patients who have not been violent but where violence is feared;

2. Inpatients who have already been violent but where there is felt to be no need for seclusion. Some helpful pointers are:

   a) All patients should be searched for weapons before they arrive on the floor.

   b) Adequate histories should be taken from patients regarding any past violence, whether or not they carry weapons; what, if any, are the "explanations" for their past violent behavior.

   c) Some patients, though chronically threatening, hostile, and frightening to others, seldom, if ever, strike out. It is important that such persons not be provoked to violence. Neither, however, can such patients be permitted to intimidate staff or other patients, or to "have the run of the ward." A firm but empathetic style, with clear-cut limit-setting, is needed when dealing with such patients. The clinician should clearly indicate that violence will not be tolerated on the ward, that the patient will be prevented from becoming violent.

   d) Potentially violent patients should be informed by those caring for them that their behavior is "frightening" to other people. The reasons why it is frightening should be explained to them. Potentially violent patients are not always aware of the extent to which their behavior disturbs others. Potentially violent patients should be informed that the staff is willing to offer them more medication, more interpersonal contact with other staff, wet packs, leather restraints, use of seclusion, or other maneuvers which the patient can request to prevent their becoming violent.

   e) Staff should recognize their own feelings of anxiety, their concern for their own safety in managing violent patients; while managing a potentially violent patient, if staff become overly anxious, the potential for that patient's violence increases. Staff are to be taught to monitor their own feelings, when to learn to ask for help, when to terminate an interview (i.e., when they feel that the patient is losing control and that they also strive towards an understanding of their own usual defense mechanisms and how they may influence a patient's potential for behaving destructively (DiBella, 1979).

VI. STAFF TRAINING, ORGANIZATION AND EDUCATION

A. A Crisis Prevention Committee has been organized to train WPIC Clinical Staff in the use of appropriate physical intervention techniques and educate staff in prediction and assessment. A unit-based program is utilized to certify nursing staff (and others) in a minimally accepted foundation of knowledge and physical performance. The certification must be renewed on an annual basis.

B. There is a crisis prevention committee that is responsible for providing instruction to clinical staff. Responsibilities include:

1. Meet regularly to plan, teach and evaluate crisis prevention classes and update information and techniques as necessary.
2. Conduct regular inservices for clinical staff and recertification.

Revised: 5/84
3/86
Reviewed: 2/88
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2/90
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Revised: 2/92

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Commission on Rehabilitation Counselor Certification
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CERTIFICATION UPDATE

The Commission on Rehabilitation Counselor Certification (CRCC) is pleased to announce that a revised Code of Professional Ethics for Rehabilitation Counselors has been completed and printed here for your use.

CRCC has worked closely with the American Rehabilitation Counseling Association and the National Rehabilitation Counseling Association in the revision of this Code. Both professional associations have adopted the Code, as well as the National Council on Rehabilitation Education. We anticipate that other professional associations will adopt or endorse the Code for their rehabilitation counselors.

You may recall that in your initial application to take the CRC Examination, you signed a statement of understanding that said you would ascribe to the Code of Ethics printed on the application. The revised Code of Professional Ethics for Rehabilitation Counselors applies to all Certified Rehabilitation Counselors. Disciplinary Procedures are outlined and all CRCs are encouraged to carefully read both the Code and Disciplinary Procedures. As stated in the Preamble to the Code, CRCs are encouraged to request in writing an advisory opinion from CRCC when they require assistance in interpreting the Code. At a later date, a Guidebook will also be developed to assist CRCs in interpreting the Canons and Rules of the Code.

CODE OF PROFESSIONAL ETHICS FOR REHABILITATION COUNSELORS

The Commission on Rehabilitation Counselor Certification has adopted the Code of Professional Ethics for Certified Rehabilitation Counselors; and the following professional organizations have adopted the Code for their memberships; American Rehabilitation Counseling Association, National Rehabilitation Counseling Association, and National Council on Rehabilitation Education.

Preamble

Rehabilitation counselors are committed to facilitating personal, social, and economic independence of individuals with disabilities. In fulfilling this commitment, rehabilitation counselors work with people, programs, institutions, and service delivery systems. Rehabilitation counselors recognize that both action and inaction can be facilitating or debilitating. Rehabilitation counselors may be called upon to provide counseling; vocational exploration; psychological and vocational assessment; evaluation of social, medical, vocational, and psychiatric information; job placement and job development services; and other rehabilitation services, and so in a manner that is consistent with their education and experience. Moreover, rehabilitation counselors also must demonstrate adherence to ethical standards and must ensure that the standards are enforced vigorously. The Code of Professional Ethics, henceforth referred to as the Code, is designed to facilitate the accomplishment of these goals.

The primary obligation of rehabilitation counselors is to their clients, defined in this Code as people with disabilities who are receiving services from rehabilitation counselors. The basic objective of the Code is to promote the public welfare by specifying and enforcing ethical behavior expected of rehabilitation counselors. Accordingly, the Code consists of two kinds of standards, Canons and Rules of Professional Conduct.

The Canons are general standards of an aspirational and inspirational nature reflecting the fundamental spirit of caring and respect which professionals share. They are maxims which serve as models of exemplary professional conduct. The Canons also express general concepts and principles from which more specific Rules are derived. Unlike the Canons, The Rules are more exacting standards that provide guidance in specific circumstances.

Rehabilitation counselors who violate the Code are subject to disciplinary action. A Rule violation is interpreted as a violation of the applicable Canon and the general principles embodied thereof. Since the use of the Certified Rehabilitation Counselor (CRC) designation is a privilege granted by the Commission on Rehabilitation Counselor Certification (CRCC), the CRCC reserves unto itself the power to suspend or to revoke the privilege or to approve other penalties for a Rule violation. Disciplinary penalties are imposed as warranted by the severity of the offense and its attendant circumstances. All disciplinary actions are undertaken in accordance with published procedures and penalties designed to assure the proper enforcement of the Code within the framework of due process and equal protection of the laws.

When there is reason to question the ethical propriety of specific behaviors, persons are encouraged to refrain from engaging in such behaviors until the matter has been clarified. Certified Rehabilitation Counselors who need assistance in interpreting the Code should request in writing an advisory opinion from the Commission on Rehabiliation Counselor Certification. Rehabilitation counselors who are not certified and require assistance in interpreting the Code should request in writing an advisory opinion from their appropriate professional organization.

Rehabilitation Counselor Code of Ethics

Canon 1 - MORAL AND LEGAL STANDARDS

Rehabilitation counselors shall behave in a legal, ethical, and moral manner in the conduct of their profession, maintaining the integrity of the Code and avoiding any behavior which would cause harm to others.

Rules of Professional Conduct

R1.1 Rehabilitation counselors will obey the laws and statutes in the legal jurisdiction in which they practice and are subject to disciplinary action for any violation, to the extent that such violation suggests the likelihood of professional misconduct.

R1.2 Rehabilitation counselors will be thoroughly familiar with, will observe, and will discuss with their clients the legal limitations of their services, or benefits offered to clients so as to facilitate honest and open communication and realistic expectations.

R1.3 Rehabilitation counselors will be alert to legal parameters relevant to their practices and to disparities between legally mandated ethical and professional standards and the Code. Where such disparities exist, rehabilitation counselors will follow the legal mandates and will formally communicate any disparities to the appropriate committee on professional ethics. In the absence of legal guidelines, the Code is ethically binding.

R1.4 Rehabilitation counselors will not engage in any act or omission of a dishonest, deceitful, or fraudulent nature in the conduct of their professional activities. They will not allow the pursuit of financial gain or other personal benefit to interfere with the exercise of sound professional judgment and skills, nor will rehabilitation counselors abuse their relationships with clients to promote personal or financial gain or the financial gain of their employing agencies.

R1.5 Rehabilitation counselors will understand and abide by the Canons and Rules of Professional Conduct which are prescribed in the Code.

R1.6 Rehabilitation counselors will not advocate, sanction, participate in, cause to be accomplished, otherwise carry out through another, or condone any act which rehabilitation counselors are prohibited from performing by the Code.

R1.7 Rehabilitation counselors' moral and ethical standards of behavior are a personal matter to the same degree as they are for any other citizen, except as these may compromise the fulfillment of their professional responsibilities or reduce the public trust in rehabilitation counselors. To protect public confidence, rehabilitation counselors will avoid public behavior that clearly is in violation of accepted moral and ethical standards.

R1.8 Rehabilitation counselors will respect the rights and reputation of any institution, organization, or firm with which they are associated when making oral or written statements. In those instances where they are critical of policies, they attempt to effect change by constructive action within organizations.

R1.9 Rehabilitation counselors will refuse to participate in employment practices which are inconsistent with the moral or legal standards regarding the treatment of employees or the public. Rehabilitation counselors will not condone practices which result in illegal or otherwise unjustifiable discrimination on any basis in hiring, promotion, or training.

Canon 2 - COUNSELOR-CLIENT RELATIONSHIP

Rehabilitation counselors shall respect the integrity and protect the welfare of people and groups with whom they work. The primary obligation of rehabilitation counselors is to their clients, defined as people with disabilities who are receiving services from rehabilitation counselors. Rehabilitation counselors shall endeavor at all times to place their clients' interests above their own.

Rules of Professional Conduct

R2.1 Rehabilitation counselors will make clear to clients, the purposes, goals, and limitations that may affect the counseling relationship.

R2.2 Rehabilitation counselors will not misrepresent their role or competence to clients. Rehabilitation counselors will provide information about their credentials, if requested, and will refer clients to other specialists as the needs of clients dictate.

R2.3 Rehabilitation counselors will be continually congnizant of their own needs, values, and of their potentially influential position, vis-a-vis clients, students, and subordinates. They avoid exploiting the trust and dependency of such persons. Rehabilitation counselors make every effort to avoid dual relationships that could impair their professional judgments or increase the risk of exploitation. Examples of dual relationships include, but are not limited to, research with and treatment of employees, students, supervisors, close friends, or relatives. Sexual intimacies with clients are unethical.

R2.4 Rehabilitation counselors who provide services at the request of a third party will clarify the nature of their relationships to all involved parties. They will inform all parties of their ethical responsibilities and take appropriate action. Rehabilitation counselors employed by third parties as case consultants or expert witnesses, where there is no pretense or intent to provide rehabilitation counseling services directly to clients, beyond file review, initial interview and/or assessment, will clearly define, through written or oral means, the limits of their relationship, particularly in the areas of informed consent and legally privileged communications, to involved individuals. As case consultants or expert witnesses, rehabilitation counselors have an obligation to provide unbiased, objective opinions.

R2.5 Rehabilitation counselors will honor the right of clients to consent to participate in rehabilitation services. Rehabilitation counselors will inform clients or the clients' legal guardians of factors that may affect clients' decisions to participate in rehabilitation services, and they will obtain written consent after clients or their legal guardians are fully informed of such factors. Rehabilitation counselors who work with minors or other persons who are unable to give voluntary, informed consent, will take special care to protect the best interests of clients.

R2.6 Rehabilitation counselors will avoid initiating or continuing consulting or counseling relationships if it is expected that the relationships can be of no benefit to clients, in which case rehabilitation counselors will suggest to clients appropriate alternatives.

R2.7 Rehabilitation counselors will recognize that families are usually an important factor in client's rehabilitation and will strive to enlist family understanding and involvement as a positive resource in promoting rehabilitation. The permission of clients will be secured prior to family involvement.

R2.8 Rehabilitation counselors and their clients will work jointly in devising an integrated, individualized rehabilitation plan which offers reasonable promise of success and is consistent with the abilities and circumstances of clients. Rehabilitation counselors will persistently monitor rehabilitation plans to ensure their continued viability and effectiveness, remembering that clients have the right to make choices.

R2.9 Rehabilitation counselors will work with their clients in considering employment for clients in only jobs and circumstances that are consistent with the clients' overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications and other relevant characteristics and needs. Rehabilitation counselors will neither place nor participate in placing clients in positions that will result in damaging the interest and welfare of either clients or employers.

Canon 3 - CLIENT ADVOCACY

Rehabilitation counselors shall serve as advocates for people with disabilities.

Rules of Professional Conduct

R3.1 Rehabilitation counselors will be obligated at all times to promote access for people with disabilities in programs, facilities, transportation, and communication, so that clients will not be excluded from opportunities to participate fully in rehabilitation, education, and society.

R3.2 Rehabilitation counselors will assure, prior to referring clients to programs, facilities, or employment settings, that they are appropriately accessible.

R3.3 Rehabilitation counselors will strive to understand accessibility problems of people with cognitive, hearing, mobility, visual and/or other disabilities and demonstrate such understanding in the practice of their profession.

R3.4 Rehabilitation counselors will strive to eliminate attitudinal barriers, including stereotyping and discrimination, toward people with disabilities and will enhance their own sensitivity and awareness toward people with disabilities.

R3.5 Rehabilitation counselors will remain aware of the actions taken by cooperating agencies on behalf of their clients and will act as advocates of clients to ensure effective service delivery.

Canon 4 - PROFESSIONAL RELATIONSHIPS

Rehabilitation counselors shall act with integrity in their relationships with colleagues, other organizations, agencies, institutions, referral sources, and other professions so as to facilitate the contribution of all specialists toward achieving optimum benefit for clients.

Rules of Professional Conduct

R4.1 Rehabilitation counselors will ensure that there is fair mutual understanding of the rehabilitation plan by all agencies cooperating in the rehabilitation of clients and that any rehabilitation plan is developed with such mutual understanding.

R4.2 Rehabilitation counselors will abide by and help to implement "team" decisions in formulating rehabilitation plans and procedures, even when not personally agreeing with such decisions, unless these decisions breach the ethical Rules.

R4.3 Rehabilitation counselors will not commit receiving counselors to any prescribed courses of action in relation to clients, when tranferring clients to other colleagues or agencies.

R4.4 Rehabilitation counselors, as referring counselors, will promptly supply all information necessary for a cooperating agency or counselor to begin serving clients.

R4.5 Rehabilitation counselors will not offer on-going professional counseling/case management services to clients receiving such services from other rehabilitation counselors without first notifying the other counselor. File review and second opinion services are not included in the concept of professional counseling/case management services.

R4.6 Rehabilitation counselors will secure from other specialists appropriate reports and evaluations, when such reports are essential for rehabilitation planning and/or service delivery.

R4.7 Rehabilitation counselors will not discuss in a disparaging way with clients the competency of other counselors or agencies, or the judgments made, the methods used, or the quality of rehabilitation plans.

R4.8 Rehabilitation counselors will not exploit their professional relationships with supervisors, colleagues, students, or employees sexually or otherwise. Rehabilitation counselors will not condone or engage in sexual harassment, defined as deliberate or repeated comments, gestures, or physical contacts of a sexual nature unwanted by recipients.

R4.9 Rehabilitation counselors who know of an ethical violation by another rehabilitation counselor will informally attempt to resolve the issue with the counselor, when the misconduct is of a minor nature and/or appears to be due to lack of sensitivity, knowledge, or experience. If the violation does not seem amenable to an informal solution, or is of a more serious nature, rehabilitation counselors will bring it to the attention of the appropriate committee on professional ethics.

R4.10 Rehabilitation counselors possessing information concerning an alleged violation of this Code, will, upon request, reveal such information to the Commission on Rehabilitation Counselor Certification or other authority empowered to investigate or act upon the alleged violation, unless the information is protected by law.

R4.11 Rehabilitation counselors who employ or supervise other professionals or students will facilitate professional development of such individuals. They provide appropriate working conditions, timely evaluations, constructive consultation, and experience opportunities.

Canon 5 - PUBLIC STATEMENTS/FEES

Rehabilitation counselors shall adhere to professional standards in establishing fees and promoting their services.

Rules of Professional Conduct

R5.1 Rehabilitation counselors will consider carefully the value of their services and the ability of clients to meet the financial burden in establishing reasonable fees for professional services.

R5.2 Rehabilitation counselors will not accept for professional work a fee or any other form of remuneration from clients who are entitled to their services through an institution or agency or other benefits structure, unless clients have been fully informed of the availability of services from other such sources.

R5.3 Rehabilitation counselors will neither give nor receive a commission or rebate or any other form of remuneration for referral of clients for professional services.

R5.4 Rehabilitation counselors who describe rehabilitation counseling or the services of rehabilitation counselors to the general public will fairly and accurately present the material, avoiding misrepresentation through sensationalism, exaggeration, or superficiality. Rehabilitation counselors are guided by the primary obligation to aid the public in developing informed judgments, opinions, and choices.

Canon 6 - CONFIDENTIALITY

Rehabilitation counselors shall respect the confidentially of information obtained from clients in the course of their work.

Rules of Professional Conduct

R6.1 Rehabilitation counselors will inform clients at the onset of the counseling relationship of the limits of confidentiality.

R6.2 Rehabilitation counselors will take reasonable personal action, or inform responsible authorities, or inform those persons at risk, when the conditions or actions of clients indicate that there is clear and imminent danger to clients or others after advising clients that this must be done. Consultation with other professionals may be used where appropriate. The assumption of responsibility for clients must be taken only after careful deliberation and clients must be involved in the resumption of responsibility as quickly as possible.

R6.3 Rehabilitation counselors will not forward to another person, agency, or potential employer, any confidential information without the written permission of clients or their legal guardians.

R6.4 Rehabilitation counselors will ensure that there are defined policies and practices in other agencies cooperatively serving rehabilitation clients which effectively protect information confidentiality.

R6.5 Rehabilitation counselors will safeguard the maintenance, storage, and disposal of the records of clients so that unauthorized persons shall not have access to these records. All non-professional persons who must have access to these records will be thoroughly briefed concerning the confidential standards to be observed.

R6.6 Rehabilitation counselors, in the preparation of written and oral reports, will present only germane data and will make every effort to avoid undue invasion of privacy.

R6.7 Rehabilitation counselors will obtain written permission from clients or their legal guardians prior to taping or otherwise recording counseling sessions. Even with guardians' written consent, rehabilitation counselors will not record sessions against the expressed wishes of clients.

R6.8 Rehabilitation counselors will persist in claiming the privileged status of confidential information obtained from clients, where communications are privileged by statute for rehabilitation counselors.

R6.9 Rehabilitation counselors will provide prospective employers with only job relevant information about clients and will secure the permission of clients or their legal guardians for the release of any information which might be considered confidential.

Canon 7 - ASSESSMENT

Rehabilitation counselors shall promote the welfare of clients in the selection, utilization, and interpretation of assessment measures.

Rules of Professional Conduct

R7.1 Rehabilitation counselors will recognize that different tests demand different levels of competence for administration, scoring, and interpretation, and will recognize the limits of their competence and perform only those functions for which they are trained.

R7.2 Rehabilitation counselors will consider carefully the specific validity, reliability, and appropriateness of tests, when selecting them for use in a given situation or with particular clients. Rehabilitation counselors will proceed with caution when attempting to evaluate and interpret the performance of people with disabilities, minority group members, or other persons who are not represented in the standardized norm groups. Rehabilitation counselors will recognize the effects of socioeconomic, ethnic, disability, and cultural factors on test scores.

R7.3 Rehabilitation counselors will administer tests under the same conditions that were established in their standardization. When tests are not administered under standard conditions, as may be necessary to accommodate modifications for clients with disabilities or when unusual behavior or irregularities occur during the testing session, those conditions will be noted and taken into account at the time of interpretation.

R7.4 Rehabilitation counselors will ensure that instrument limitations are not exceeded and that periodic reassessments are made to prevent stereotyping of clients.

R7.5 Rehabilitation counselors will make known the purpose of testing and the explicit use of the results to clients prior to administration. Recognizing the right of clients to have test results, rehabilitation counselors will give explanations of test results in language clients can understand.

R7.6 Rehabilitation counselors will ensure that specific interpretation accompanies any release of individual data. The welfare and explicit prior permission of clients will be the criteria for determining the recipients of the test results. The interpretation of assessment data will be related to the particular goals of evaluation.

R7.7 Rehabilitation counselors will attempt to ensure, when utilizing computerized assessment services, that such services are based on appropriate research to establish the validity of the computer programs and procedures used in arriving at interpretations. Public offering of an automated test interpretation service will be considered as a professional-to-professional consultation. In this instance, the formal responsibility of the consultant is to the consultee, but the ultimate and overriding responsibility is to clients.

R7.8 Rehabilitation counselors will recognize that assessment results may become obsolete. They make every effort to avoid and prevent the misuse of obsolete measures.

Canon 8 - RESEARCH ACTIVITIES

Rehabilitation counselors shall assist in efforts to expand the knowledge needed to more effectively serve people with disabilities.

Rules of Professional Conduct

R8.1 Rehabilitation counselors will ensure that data for research meet rigid standards of validity, honesty, and protection of confidentiality.

R8.2 Rehabilitation counselors will be aware of and responsive to all pertinent guidelines on research with human subjects. When planning any research activity dealing with human subjects, rehabilitation counselors will ensure that research problems, design, and execution are in full compliance with such guidelines.

R8.3 Rehabilitation counselors presenting case studies in classes, professional meetings, or publications will confine the content to that which can be disguised to ensure full protection of the identity of clients.

R8.4 Rehabilitation counselors will assign credit to those who have contributed to publications in proportion to their contribution.

R8.5 Rehabilitation counselors recognize that honesty and openness are essential characteristics of the relationship between rehabilitation counselors and research participants. When methodological requirements of a study necessitate concealment or deception, rehabilitation counselors will ensure that participants understand the reasons for this action.

Canon 9 - COMPETENCE

Rehabilitation counselors shall establish and maintain their professional competencies at such a level that their clients receive the benefit of the highest quality of services the profession is capable of offering.

Rules of Professional Conduct

R9.1 Rehabilitation counselors will function within the limits of their defined role, training, and technical competency and will accept only those positions for which they are professionally qualified.

R9.2 Rehabilitation counselors will continuously strive through reading, attending professional meeting, and taking courses of instruction to keep abreast of new developments, concepts, and practices that are essential to providing the highest quality of services to their clients.

R9.3 Rehabilitation counselors, recognizing that personal problems and conflicts may interfere with their professional effectiveness, will refrain from undertaking any activity in which their personal problems are likely to lead to inadequate performance. If they are already engaged in such activity when they become aware of their personal problems, they will seek competent professional assistance to determine whether they should suspend, terminate or limit the scope of their professional activities.

R9.4 Rehabilitation counselors who are educators will perform their duties based on careful preparation so that their instruction is accurate, up-to-date and scholarly.

R9.5 Rehabilitation counselors who are educators will ensure that statements in catalogs and course outlines are accurate, particularly in terms of subject matter covered, bases for grading, and nature of classroom experiences.

R9.6 Rehabilitation counselors who are educators will maintain high standards of knowledge and skill by presenting rehabilitation counseling information fully and accurately, and by giving appropriate recognition to alternative viewpoints.

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Canon 10 - CRC CREDENTIAL

Rehabilitation counselors holding the Certified Rehabilitation Counselor (CRC) designation shall honor the integrity and respect the limitations placed upon its use.

Rules of Professional Conduct

R10.1 Certified Rehabilitation Counselors will use the Certified Rehabilitation Counselor (CRC) designation only in accordance with the relevant GUIDELINES promulgated by the Commission on Rehabilitation Counselor Certification.

R10.2 Certified Rehabilitation Counselors will not attribute to the mere possession of the designation depth or scope of knowledge, skill, and professional capabilities greater than those demonstrated by achievement of the CRC designation.

R10.3 Certified Rehabilitation Counselors will not make unfair comparisons between a person who holds the Certified Rehabilitation Counselor (CRC) designation and one who does not.

R10.4 Certified Rehabilitation Counselors will not write, speak, nor act in ways that lead others to believe Certified Rehabilitation Counselors are officially representing the Commission on Rehabilitation Counselor Certification, unless such written permission has been granted by the said Commission.

R10.5 Certified Rehabilitation Counselors will make no claim to unique skills or devices not available to others in the profession unless the special efficacy of such unique skills or device has been demonstrated by scientifically accepted evidence.

R10.6 Certified Rehabilitation Counselors will not initiate or support the candidacy of an individual for certification by the Commission on Rehabilitation Counselor Certification if the individual is known to engage in professional practices which violate this Code.

Acknowledgement

Referenced documents, statements, and sources for the development of this revised Code are as follows: National Rehabilitation Counseling Association Code of Ethics, National Academy of Certified Clinical Mental Health Counselors, and the Ethical Standards of the American Association for Counseling and Development. Portions of the Code are also derived from the American Psychological Association "Ethical Principles of Psychologists."

STANDARDS OF PRACTICE

NEUROPSYCHOLOGICAL ASSESSMENT AND REHABILITATION SERVICES

1. Staff will be familiar with, observe and discuss with their patients the limitations and potential benefits of services offered so as to facilitate honest and open communications and realistic expectations.

2. Staff will respect the rights and reputation of any institution, organization or firm with which they are associated when making oral or written statements, and when critical of particular policies, will attempt to seek change through constructive actions.

3. Staff will be obligated to promote access for persons with disabilities in all areas of their lives, assuring accessibility of programs or facilities at the time of referral, striving to eliminate attitudinal barriers and enhancing their own sensibility and awareness towards persons with disabilities.

4. Staff will function within the limits of their defined role, training and technical competency, accepting only those positions for which they are professionally qualified and seeking consultation and supervision as appropriate and necessary.

5. Staff will respect the confidentiality of information obtained from patients as well as informing them of the limits of confidentiality at the onset of the counseling relationship.

6. Confidentiality will only be broken when the conditions or actions of patients indicate that there is clear and imminent danger to themselves or others.

7. Staff will safeguard the maintenance, storage, and disposal of all patient records and must have written permission from patients or their legal guardians in order to forward any confidential information.

8. Staff will recognize that each test or inventory demands specific levels of competence for administration, scoring, and interpretation, and will recognize the limits of their competence and perform only those functions for which they are qualified.

9. Staff will consider carefully the validity, reliability and appropriateness of tests (inventories) when selecting and administering them for use in a given situation or with particular patients. Staff will proceed with caution when attempting to evaluate and interpret the performance of persons who are not represented in the standardized norm groups and will recognize the effects of socioeconomic, disability and cultural factors on test scores.

10. Staff will make known the purpose of testing and the explicit use of the results to patients prior to administration. Following testing, staff will interpret test results in an understandable, empathic, and reality-based manner.

11. Staff and their patients will work jointly in devising an integrated, individualized treatment plan which offers reasonable promise of success and is consistent with the abilities and circumstances of clients. Staff will consistently monitor treatment plans every four months to ensure their continued viability and effectiveness, remembering that patients have the right to make choices.

12. Staff will work with patients in considering rehabilitation objectives that are consistent with the patients' overall abilities, limitations, temperament, interests, and other relevant characteristics and needs.

13. Staff will recognize that families are an important factor in a patient's rehabilitation and will strive to enlist family understanding and involvement as a positive resource in promoting rehabilitation goals. The permission of clients will be secured prior to family involvement.

14. Staff will ensure that data for research, case study presentations, professional meetings, and publications meet rigid standards of validity, honesty and protection of confidentiality.

15. Staff will ensure that there is mutual understanding of the rehabilitation plan by all agencies and clinicians cooperating in the treatment and rehabilitation of patients including the sharing and procurement of patient information as appropriate.

16. Staff who are Certified Rehabilitation Counselors will function in accordance with the GUIDELINES promulgated by the Commission on Rehabilitation Counselor Certification.

University of Pittsburgh
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
Neuropsychological Assessment and Rehabilitation Services

STANDARDS OF EDUCATIONAL AND PSYCHOLOGICAL TESTING, 1985

AMERICAN EDUCATIONAL RESEARCH ASSOCIATION
AMERICAN PSYCHOLOGICAL ASSOCIATION
NATIONAL COUNCIL ON MEASUREMENT IN EDUCATION

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Introduction

Educational and psychological testing represents one of the most important contributions of behavioral science to our society. It has provided fundamental and significant improvements over previous practices in industry, government, and education. It has provided a tool for broader and more equitable access to education and employment. Although not all tests are well-developed, nor are all testing practices wise and beneficial, available evidence supports the judgment of the Committee on Ability Testing of the National Research Council that the proper use of well-constructed and validated tests provides a better basis for making some important decisions about individuals and programs than would otherwise be available.

Educational and psychological testing has also been the target of extensive scrutiny, criticism, and debate both outside and within the professional testing community. The most frequent criticisms are that tests play too great a role in the lives of students and employees and that tests are biased and exclusionary. In consideration of these and other criticisms, the *Standards* is intended to provide a basis for evaluating the quality of testing practices as they affect the various parties involved.

Participants in the Testing Process

Educational and psychological testing involves and significantly affects individuals, institutions, and society as a whole. The individuals affected include students, parents, teachers, educational administrators, job applicants, employees, patients, supervisors, executives, and evaluators. The institutions affected include schools, colleges, businesses, industry, and government agencies. Individuals and institutions benefit when testing helps them achieve their goals. Society, in turn, benefits when the achievement of individual and institutional goals contributes to the general good.

The interests of the various parties in the testing process are usually, but not always, congruent. For example, when a test is given for counseling purposes or for job placement, the interests of the individual and the institution often coincide. However, when a test is used to select from among many individuals for a highly competitive job or educational or training program, the preferences of an applicant may be inconsistent with those of an employer or admissions officer.

There are generally three main participants in the testing process: the *test developer*, who develops, publishes, markets, and often administers and scores the test; the *test user*, who requires the test results for some decision-making purpose; and the *test taker*, who takes the test by choice, direction, or necessity. Often there is a *test sponsor*, which may be a board that represents institutions or a governmental agency, that contracts with a test developer for a specific instrument or service. In addition there may also be a *test administrator*, who handles the actual administration of the test, and a *test reviewer*, who conducts a scholarly review to evaluate the suitability of the test for the uses proposed.

The roles of test developer, test taker, test user, and test sponsor are sometimes combined and sometimes further divided. In counseling, the test taker is typically the primary user of the test results. Sometimes the test administrator is an agent of the test developer, and sometimes the test administrator is also the test user. When an industrial organization prepares its own employment tests, it is both the developer and the user. Sometimes a test is developed by a test author but published, advertised, and distributed by an independent publisher, though in most cases the publisher plays an active role in the test development.

The Purpose of These Standards

Recent controversies over testing make the development of the *Standards* vitally important to all participants in the testing process. Many issues need to be addressed in a way that does not preempt the political process. In general, the *Standards* advocates that, within feasible limits, the necessary technical information be made available so that those involved in policy debate may be fully informed. The *Standards* does not attempt to provide psychometric answers to policy questions. However, complete separation of scientific and social concerns is not possible. The requirement in the *Standards* for documentation and scientific analysis may sometimes, in itself, place a greater burden on one side of a policy issue than on another.

The purpose of publishing the *Standards* is to provide criteria for the evaluation of tests, testing practices, and the effects of test use. Although the evaluation of the appropriateness of a test or application should depend heavily on professional judgment, the *Standards* can provide a frame of reference to assure that relevant issues are addressed. The *Standards* does not attempt to assign precise responsibility for the satisfaction of individual standards. To do so would be difficult, especially since much work in testing is done by contractual arrangement. However, all professional test developers, sponsors, publishers, and users should make reasonable efforts to observe the *Standards* and to encourage others to do so.

The *Standards* is not meant to prescribe the use of specific statistical methods. Where specific statistical reporting requirements are mentioned, the phrase "or equivalent" should always be understood. For concreteness, the standards sometimes refer to a common method of achieving specific reporting objectives. In particular situations, however, more desirable alternatives may be available.

Cautions To Be Exercised in Using These Standards

The *Standards* is a technical guide that can be used as the basis for evaluating testing practices. Evaluating the acceptability of a test or test application does not rest on the literal satisfaction of every primary standard in this document, and acceptability cannot be determined by using a checklist. Specific circumstances affect the importance of individual standards. Individual standards should not be considered in isolation. Therefore, evaluating acceptability involves the following: professional judgment that is based on a knowledge of behavioral science, psychometrics, and the professional field to which the tests apply; the degree to which the intent of this document has been satisfied by the test developer and user; the alternatives that are readily available; and research and experiential evidence regarding feasibility.

The use of the standards in litigation is inevitable; it should be emphasized, however, that in legal proceedings and elsewhere professional judgment based on the accepted corpus of knowledge always plays an essential role in determining the relevance of particular standards in particular situations. The *Standards* is intended to offer guidance for such judgments.

It would not be appropriate for test developers or test users to state that a test, manual, or procedure satisfies or follows these standards. That judgment is more appropriately made by others in the professional community.

These standards are concerned with a field that is evolving. Therefore, there is a continuing need for monitoring and revising this document as knowledge develops. There are some areas in which new developments are particularly likely, such as gender-specific or combined-gender norms, cultural bias, computer based test interpretation, validity generalization, differential prediction, and flagging test scores for people with handicapping conditions.

Categories of Standards

In previous versions of the *Standards*, the classifications "essential," "highly desirable," and "desirable" were used to indicate the relative importance of the individual standards. In the 1985 *Standards*, new categories and labels are used, in part to avoid the troublesome distinction between desirable and highly desirable and to avoid the label "essential." The standards are now categorized either as being of primary or of secondary importance. Importance is viewed largely as a function of the potential impact that the testing process has on individuals, institutions, and society.

Primary standards are those that should be met by all tests before their operational use and in all test uses, unless a sound professional reason is available to show why it is not necessary, or technically feasible, to do so in a particular case. Test developers and users and, where appropriate, sponsors, are expected to be able to explain why any primary standards have not been met.

Secondary standards are desirable as goals but are likely to be beyond reasonable expectation in many situations. Although careful consideration of these standards will often be helpful in evaluating tests and programs and in comparing the usefulness of competing instruments, limitations on resources may make adherence to them infeasible in many situations. Some secondary standards describe procedures that are beneficial but not often used. Test developers and users are not expected to be able to explain why secondary standards have not been met.

The importance of some standards for test construction and evaluation will vary with application. These standards are designated as *conditional*. Such standards should be considered primary for some situations and secondary for others. In deciding whether to take an individual conditional standard as primary or secondary, one should consider carefully the feasibility of meeting that standard in relation to the potential consequences to all parties involved in the testing process. It may be infeasible technically or financially for some testing programs to observe some conditional standards, particularly those programs that conduct low-volume tests. However, if the use of a test is likely to have serious consequences for test takers, especially if a large number of people may be affected, conditional standards assume increased importance.

The categories in which standards are placed should be viewed as imperfect. Where testing has a limited role in a larger assessment procedure (e.g., tests conducted by a clinical, industrial, or school psychologist), some primary standards, especially those dealing with documentation, should be considered as having a secondary designation.

Ideally all relevant primary standards should be met at publication or first operational use of each test. Because the development of a test for widespread use is an extensive undertaking, a requirement that all relevant primary standards be satisfied at first operational use would be likely to stifle both the development of new instruments and progress in the field. Furthermore, a testing professional who is put in charge of a new or continuing program that does not meet relevant primary standards cannot be expected to remedy all that program's shortcomings immediately.

When judging the short-term acceptability of a test or program under development or redevelopment, the test user should determine that the test is on a par with readily available alternatives. In addition, the test developer or publisher should determine that

1. advertising for a test or program recommends only applications supported by the test's research base;
2. necessary cautions are given in the manual or elsewhere to encourage sufficiently limited reliance on the test results, particularly when the use of the new test will have significant impact on the test takers; and
3. there is clear indication of continuing and significant improvement in the research base directed toward observance of the standards.

Tests and Test Uses to Which These Standards Apply

The major new sections in the 1985 *Standards* relate to test use. The *Standards* emphasizes that test users should have a sound technical and professional basis for their actions, much of which can be derived from research done by test developers and publishers. In selecting a test, a potential user should depend heavily upon the developer's research documentation that is clearly related to the intended application. Although the test developer should supply the needed information, the ultimate responsibility for appropriate test use lies with the user.

Tests include standardized ability (aptitude and achievement) instruments, diagnostic and evaluative devices, interest inventories, personality inventories, and projective instruments. The 1966 and 1974 *Standards* noted that the same general types of information are needed for all these varieties of published diagnostic, prognostic, and evaluative devices. Similarly, a more appropriate choice among assessment devices and subsequent use will be facilitated if there is reasonable comparability in the kinds of information made available to users.

In the *Standards* three broad categories of test instruments are covered: constructed performance tasks, questionnaires, and to a lesser extent, structured behavior samples. Constructed performance tasks are designed to isolate and assess particular educational and psychological constructs without having to simulate actual environmental or social situations in which such constructs are typically expressed. Printed answer sheets and pencil are the mediums most often used; however, oral exchange, oral recordings, and manipulatable objects form parts of some individually administered tests, and computerized test administration is becoming increasingly common. The performance tasks are often designed to be interpreted as maximum performance assessments. Conventional standardized ability tests are the most common examples. There are also constructed performance measures of some cognitive style and personality constructs.

Questionnaires and inventories are designed to provide a convenient medium through which people can be asked to report personal opinions, interests, attitudes, and typical reactions to situations and problems that have been or might be faced in everyday life. Personality or interest inventories, composed of lists of printed questions that the respondent answers by checking a defined degree of agreement or interest, are the most common examples.

Observable behavior can also be sampled directly to provide systematic, standardized assessments of personal skills and styles relevant to clinical, employment, and educational decision making. Such tests are called structured behavior sample tests. Social skills, speaking and writing skills, and the skills involved in artistic expression are examples of performance domains in which structured behavior samples have been used. Job sample tests have been used often in industry and in the military. Writing samples are now used widely in education. Tests of characteristic styles of performance under stress, in the face of complexity, or in situations where leadership is required provide other examples. Sometimes structured behavior samples are taken by observing behavior in real-world situations. In other instances, such situations are simulated to aid in standardization or for reasons of economy.

The need for reasonable comparability of the information provided to users is particularly compelling for the new uses of computers in testing that are being developed. Instruments developed initially in paper-and-pencil or interview form are being administered, scored, and in some instances, interpreted, by computers. There are also computerized adaptive tests and interviews. Although in some instances specific standards have been stated for tests administered by computer, all the standards apply with equal force to such tests. In many instances, the switch from paper and pencil to computer assessment will require additional evidence that relevant standards have been met in the new testing mode.

Although these standards apply primarily to constructed performance tasks, questionnaires, and structured behavior samples, they may also be usefully applied in varying degrees to the entire range of assessment techniques. It will generally not be possible, however, to apply the standards with the same rigor to the broad range of unstructured behavior samples that are used in some forms of clinical and school psychological assessment and to instructor-made tests that are used to evaluate student performance in education and training.

The term "test" usually refers to measures of either the constructed performance or structured behavior sample type, in which test takers are expected or instructed to try their best. Instruments for identifying interests and personality characteristics through self-report are typically and properly entitled "inventories," "questionnaires," or "checklists" rather than tests. In textual material, such as in the *Standards*, these self-report instruments may be called tests in order to simplify the language. The are called tests here to indicate that the standards also apply to these instruments. The term "test" should generally be avoided, however, in describing such instruments, especially in their titles.

Organization of This Volume

Part I of the *Standards*, "Technical Standards for Test Construction and Evaluation," contains standards for validity, reliability, test development, scaling, norming, comparability, equating, and publication. Part II presents "Professional Standards for Test Use." Part III, "Standards For Particular Applications," contains standards for testing linguistic minorities and people with handicapping conditions. The technical and professional standards discussed in Parts I and II are relevant to the particular applications in Part III. Part IV, "Standards for Administrative Procedures," contains standards regarding test administration, scoring, and reporting, as well as standards for the protection of test takers' rights. Although all four parts deal with technical issues, each also addresses how technical issues, professional practice, and professional ethics interface. The interface of standards with issues of professional practice is most evident in Part II and that with professional ethics in Part IV.

Each chapter begins with introductory text that provides background for the standards that follow. This text is meant to assist in the interpretation of the standards, not to impose additional standards. Many of the standards are followed by comments. These comments are not meant to impose additional requirements, only to explain the standards they follow.

The *Standards* also contains a glossary, a bibliography, and an index. The glossary provides definitions for terms as they are used in this volume specifically.

6. General Principles of Test Use

Background

Although a distinction is made in the *Standards* between test development and test use, that distinction is not always clear in application. For example, test administration, scoring, and reporting may be done by the test developer or the test user. Also users need to be aware of standards governing test development so that they can more easily evaluate the tests they contemplate using. This chapter contains general standards applicable to test use in professional practice. Succeeding chapters in this section present standards more specific to specialty areas.

In applying standards to test use, as opposed to test development, more flexibility and use of professional judgment are required. The appropriateness of specific test uses cannot be evaluated in the abstract but only in the context of the larger assessment process. The principal questions to be asked in evaluating test use are whether or not the test is appropriate (valid) for its specific role in the larger assessment process and whether or not the test user has accurately described the extent to which the score supports any decision made or administrative action taken.

Although it is not appropriate to tell a test user that particular levels of predictive validity and reliability need to be met, it is appropriate to ask the user to ascertain that procedures result in adequately valid predictions or reliable classifications for the purposes of the testing. Cost-benefit compromises become as necessary in test use as they do in test development. However, as with standards for test development, when test standards are not met in test use, reasons should be available. Here again, the criteria of impact on test takers applies. The greater the potential impact, the greater the need to satisfy relevant standards.

The test user, in selecting or interpreting a test, should know the purposes of the testing and the probable consequences. The user should know the procedures necessary to facilitate effectiveness and to reduce bias in test use. Although the test developer and publisher should provide information on the strengths and weaknesses of the test, the ultimate responsibility for appropriate test use lies with the test user. The user should become knowledgeable about the test and its appropriate uses and also communicate this information, as appropriate, to others.

Standard 6.1

Test users should evaluate the available written documentation on the validity and reliability of tests for the specific use intended. *(Primary)*

Comment:
The degree of reliability or validity required of a test depends on its role in the assessment process and the impact of the process on the parties involved. There may be situations in which, in a user's professional judgment, decisions or inferences should be based, in part, on tests for which there is little evidence of reliability or validity for the intended use. In these situations, the user should take great care not to imply that the decisions or inferences made are based on test results of known reliability or validity. When feasible, repeated use of such tests should include efforts to develop the appropriate evidence.

Standard 6.2

When a test user makes a substantial change in test format, mode of administration, instructions, language, or content, the user should revalidate the use of the test for the changed conditions or have a rationale supporting the claim that additional validation is not necessary or possible. *(Primary)*

Standard 6.3

When a test is to be used for a purpose for which it has not been previously validated, or for which there is no supported claim for validity, the user is responsible for providing evidence of validity. ***(Primary)***

Comment:
The individual who makes the claim for validity is responsible for providing the necessary evidence. Evidence of validity sufficient for test use may often be obtained from a well-documented manual. If previous evidence is not sufficient, then additional data should be collected. The provisions of this standard should not be construed to prohibit the generation of hypotheses from test data. For example, though many clinical tests have limited or contradictory validity evidence for common uses, clinicians generate hypotheses based appropriately on responses to such tests. These hypotheses should, however, be labeled clearly as such.

Standard 6.4

Test users should accurately portray the relevance of a test to the assessment and decision-making process and should not use a test score to justify an evaluation, recommendation, or decision that has been made largely on some other basis. ***(Primary)***

Standard 6.5

Test users should be alert to probable unintended consequences of test use and should attempt to avoid actions that have unintended negative consequences. ***(Primary)***

Comment:
For example, test users should act to counter the tendency of people to attach unsupported surplus meanings to test scores. Obviously, test users cannot anticipate every unintended consequence. What is required is an attempt that is reasonable and made in good faith to avoid unintended consequences that might be anticipated.

Standard 6.6

Responsibility for test use should be assumed by or delegated only to those individuals who have the training and experience necessary to handle this responsibility in a professional and technically adequate manner. Any special qualifications for test administration or interpretation noted in the manual should be met. ***(Primary)***

Comment:
This standard has special significance in areas such as clinical testing, testing for special education, testing of handicapped people, and other such situations where potential impact is great.

Standard 6.7

Test users should verify periodically that changes in populations of test takers, objectives of the testing process, or changes in available techniques have not made their current procedures inappropriate. ***(Conditional)***

Standard 6.8

When test results are released to the news media, those responsible for releasing the results should provide information to help minimize the possibility of the misinterpretation of the test results. ***(Primary)***

Standard 6.9

When a specific cut score is used to select, classify, or certify test takers, the method and rationale for setting that cut score, including any technical analyses, should be presented in a manual or report. When cut scores are based primarily on professional judgment, the qualifications of the judges also should be documented. ***(Primary)***

Comment:
In employment and some other testing applications there may be no prespecified cut score; the number of individuals to be selected is determined by the number of available openings.

Standard 6.10

In educational, clinical, and counseling applications, test administrators and users should not attempt to evaluate test takers whose special characteristics--ages, handicapping conditions, or linguistic, generational, or cultural backgrounds--are outside the range of their academic training or supervised experience. A test user faced with a request to evaluate a test taker whose special characteristics are not within his or her range of professional experience should seek consultation regarding test selection, necessary modifications of testing procedures, and score interpretation from a professional who has had relevant experience. ***(Primary)***

Standard 6.11

In school, clinical, and counseling applications, a test taker's score should not be accepted as a reflection of lack of ability with respect to the characteristic being tested for without consideration of alternate explanations for the test taker's inability to perform on that test at that time. ***(Conditional)***

Comment:
Many test manuals point out variables that should be considered in interpreting test scores, such as clinically relevant history, school record, vocational status, and examiner or test taker differences. Influences associated with variables such as socioeconomic status, ethnicity, cultural background, language, age, or gender may also be relevant. In addition, medication, visual impairments, or other handicapping conditions may affect a test taker's performance on, for example, a paper-and-pencil test of mathematics. Such alternate explanations for a test taker's level of performance should be considered before interpreting the test taker's score as reflecting ability level with respect to the skills being tested.

Standard 6.12

In school, clinical, and counseling applications, tests developed for screening should be used only for identifying test takers who may need further evaluation. The results of such tests should not be used to characterize a person or to make any decision about a person, other than the decision for referral for further evaluation, unless adequate reliability and validity for these other uses can be demonstrated. ***(Primary)***

Standard 6.13

Test users should not use interpretations of test results, including computer-interpreted test results, unless they have a manual for that test that includes information on the validities of the interpretations for the intended applications and on the samples on which they were based. *(Primary)*

Comment:
The user of a special service has the obligation to be thoroughly familiar with the principles on which interpretations are derived and should have the ability to evaluate a computer-based interpretation of test performance in light of other evidence. Considerable professional judgment is needed to use computer-based interpretations appropriately.

7. Clinical Testing

Background

The use of tests as part of a clinical assessment is characterized mainly by the fact that the choice of tests is individualized and usually only one person at a time is tested. The test taker may be a child, adolescent, or adult; the setting may be a school, mental health or outpatient clinic, hospital, prison, or private practitioner's office. In any event, tests are chosen to provide information useful for assessment and decision making for that specific individual, taking into account his or her special background and characteristics.

A wide range of tests and procedures is employed, including tests of aptitudes or abilities, attitudes, and personality characteristics; projective techniques; interview schedules; checklists; behavioral observations; rating scales; and others. Tests are used to make decisions about diagnostic classification; presence of neurological impairment; suitability for particular types of treatment or educational instruction; identification of intellectual and personality assets that can be used in rehabilitative, therapeutic, or educational planning; eligibility for parole or probation; and evaluation of treatment outcomes. In many clinical situations decision making is fluid in that treatment yields additional information that can serve to modify the decisions. In other circumstances clinical testing may be involved in decisions having a powerful and lasting impact on people's lives (e.g., parole, sentencing, civil commitment, competency to stand trial, and child custody).

Projective techniques and many interview and behavioral observation techniques are often used as aids in clinical assessment and treatment selection. Each of these methods yields multiple hypotheses regarding the behavior of the subject in various situations as they arise, with each hypothesis modifiable on the basis of further information. When one of these measures is so used, interpretations are judged by its total contribution to the clinical understanding of an individual rather than by the validity of each hypothesis.

Computers are being used increasingly to administer, score, and interpret tests. However, whether clinicians do the testing themselves or employ a computer or an assistant, they have the responsibility of selecting the appropriate tests for a specific individual in accordance with that person's unique characteristics, the setting, and the nature of the question posed. Clinicians are also responsible for ensuring that the testing conditions are appropriate. For example, such matters as whether a client who needs glasses or a hearing aid has them available during testing can affect the validity of test results. Is the client capable of reading at the level required by the test? Is the test material suitable for this elderly or young client? In addition, it is the clinician's responsibility to assure confidentiality, assess the suitability of test results and computer interpretations, and communicate them in appropriate terms to the client and concerned others.

A number of special problems arise in the use of instruments for clinical assessment. Such instruments are often multiply scored. Intercorrelations among the resulting scales are often high due to the common format, item overlap, and overlapping constructs. Furthermore, even though scores may be standardized with respect to a reference group, interpretations are often based on the absolute level of standard scores or of their differences rather than on scores relative to those obtained by others. Appropriately, manuals sometimes contain the warning that score levels should be interpreted with caution and that interpretations obtained by examining several independently obtained sources is desirable.

Another area requiring special attention is that of open-ended responses. Examples of clinical instruments involving these are sentence completion forms, analyses of verbal material obtained from tape recordings or videotapes of interviews or therapy sessions, and ratings of behavior in natural or contrived settings. Special care is needed with such approaches to ensure that the instruments are administered in a facilitating atmosphere without suggestions or cues that might influence the response given, unless such prompting is specifically planned as part of the test. Furthermore, the scoring categories used in open-ended response instruments need to be defined clearly, and special training may be needed for coding the responses.

Chapter 1 describes the three categories of evidence of test validity that should be considered in interpreting test scores. Of these, construct-related evidence is of primary importance for clinical and personality tests. Interpretations of personality traits, attitudes, underlying personality tendencies, and psychiatric classifications are all constructs requiring evidence of validity. Content-related and criterion-related evidence may sometimes be a part of construct evidence.

Clinicians deal not only with the diagnostic uses of tests, but also with the prediction of behavior and with response to treatment. When clinical instruments are used in decision making, that use is constrained by the same consideration of criterion-related evidence of validity as is any other use of tests.

Standard 7.1

Clinicians should not imply that interpretations of test data are based on empirical evidence of validity unless such evidence exists for the interpretations given. ***(Primary)***

Comment:
This standard should not be construed to prohibit interpretations of test data presented as hypotheses or clinical judgments.

Standard 7.2

When validity is appraised by comparing the level of agreement between test results and clinical diagnoses, the diagnostic terms or categories employed should be carefully defined or identified, and the method by which a diagnosis was made should be specified. If diagnosis was made based on judgments, information on the training, experience, and professional status of the judges and on the nature and extent of the judges' contacts with the test takers should be included. ***(Primary)***

Standard 7.3

When differential diagnosis is needed, the user should choose, if possible, a test for which there is evidence of the test's ability to distinguish between the two or more diagnostic groups of concern rather than merely to distinguish abnormal cases from the general population. ***(Primary)***

Comment:
Test users will find it particularly helpful if validity information is in a form that enables them to determine how much confidence can be placed in judgments regarding an individual. Differences between group means and their statistical significance give inadequate information regarding validity for diagnostic purposes. Further information might consist of a table showing the degree of overlap of predictor distributions among different criterion groups.

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Standard 7.4 Test users should determine from the manual or other reported evidence whether the construct being measured corresponds to the nature of the assessment that is intended. *(Primary)*

Standard 7.5 Clinicians should share with their clients test results and interpretations, as well as information about the range of error for such interpretations when such information will be beneficial to the client. Such information should be expressed in language that the client (or client's legal representative) can understand. *(Secondary)*

Standard 7.6 Criterion-related evidence of validity for populations similar to that for which the test will be used should be available when recommendations or decisions are presented as having an actuarial, as well as a clinical, basis. *(Primary)*

9. Test Use in Counseling

Background

Uses of tests in counseling differ from most other test uses in that the test taker is viewed as the primary user of test results. Accumulated experience and research evidence have shown that standardized tests can be a valuable part of the counseling process. If used appropriately, tests can provide useful information to clients. However, because test takers do not typically have professional testing knowledge and skill, they need assistance and guidance from counselors and developers of interpretive materials who have a unique role in facilitating the appropriate and effective use of tests.

Counselors are concerned with a range of assessment and guidance activities related to the life-span development and decision-making activities of individuals. Typical counseling concerns include the individual's personal and social skills, educational achievement, developed abilities, educational and vocational interests, occupational knowledge and preferences, occupational values, career development, study skills, coping and problem solving skills, and plans and values for other important roles in adult life, such as relationships with others, work, and parenting. These characteristics of the individual are assessed in counseling by a variety of formal and informal procedures--paper-and-pencil inventories, tests, work samples, interviews, card sorts, checklists, and so on. All such measures that yield classifications and raw or converted scores that result in suggestions for exploration or recommendations for action are considered tests and require evidence of reliability and validity.

Counselors work in a variety of settings: schools, government, industry, agencies, and private practice. They may assist individuals in examining educational, career, work, family, leisure, and retirement choices. One important function in schools is that of consulting with administrators, teachers, parents, and students to assist individual students in the selection of educational programs. When tests are an important part of the decision process, the tests may, in effect, become the basis for the placement of students. School counselors may play a similar role in assisting individuals in choosing colleges and in making decisions about college programs. In these cases the standards for the use of tests in educational classification and placement may be appropriate.

All interpretive reports, whether provided in printed form or on video display terminals, are an extension of the individual profiles and score reports that are part of the counseling testing program. They may be used to provide the results of tests to students and parents, as well as to professional staff. Depending on the availability of counselors and other school staff who are trained in test interpretation and use, students who receive computer-based interpretation reports may or may not receive further interpretation of such reports. For many tests used in schools, therefore, test developers need to take into account the likelihood that students will receive little or no professional assistance in interpreting test results other than that provided by the computer-based interpretation reports. The test taker, who has no technical training in testing, must be able to interpret and use test information accurately and must depend largely on materials accompanying the computer-based interpretation report. The developers of such tests or computer-based interpretations should provide comprehensive and easily understandable interpretive and instructional material.

Computer-assisted guidance systems are also within the scope of the *Standards*. These systems may incorporate test-like tasks or existing interest or ability measures. Results of rating scales, ability measures, or estimates may be used to structure the search for occupations. Occupations are sometimes presented or recommended to users on the basis of measures of occupational attributes. Manuals should spell out the procedures by which occupational characteristics were developed, the system by which occupational attributes were linked to individual characteristics, and evidence on the validity of particular recommendations.

Test interpretations and test uses in counseling for vocational, career, and life development are influenced by the experiences of the individual test taker and of the professionals who provide information in this process. To some degree these experiences, in interactions with peers and adults and in schools and other settings, have been group-linked and related to fixed characteristics of individuals (e.g., gender, race or ethnicity, or socioeconomic background). Test interpretation and test use may similarly be limited by perceptions and experiences related to group membership. This issue is of particular concern in uses of tests in counseling. Both counselor and test taker should consider whether learning experiences leading to the development of preferences and competencies have been stereotyped by expectations of behaviors considered appropriate for females and males, for racial and ethnic minorities, based on socioeconomic status, or for people with handicapping conditions.

Standard 9.1

Testing for counseling should have as its primary goals the acquisition of relevant information and the reporting of that information with appropriate interpretations so that clients from diverse backgrounds can be assisted in making important educational, personal, and career decisions. ***(Primary)***

Standard 9.2

Counselors should review the interpretive materials provided to clients to evaluate accuracy, clarity, and usefulness of the materials. Manuals for tests or computer-based interpretations should be evaluated for evidence for the validity of specific interpretations made. ***(Primary)***

Comment:
A counselor should determine, for example, whether classifications for particular vocational courses are based on cut scores supported by evidence of successful course completion or on other criteria. Are occupational suggestions based on empirical study of people entering the occupations? The bases of such interpretations should be stated clearly, perhaps by presenting expectancy tables or probability statements. For some tests this information may vary for groups of test takers. Qualified professional users should have access to explicit information on the accuracy of the classifications used as the basis of interpretations. If data to support such interpretive statements have not been collected, that fact should be stated clearly.

Standard 9.3

Counselors should review technical data and develop a rationale for the decision to use combined or separate norms for females and males in reports to test takers. ***(Primary)***

Comment:
This standard is concerned with the possible effect of prior experience on present choices. For example, in tests that are used for choosing vocational courses, scores for female test takers may reflect present status but may not predict future performance in a vocational course. One way to examine this possibility is to compare an individual's standing relative to others in the same gender group. Comparing both norm groups provides an opportunity to discuss the influence of prior

experiences on test scores and to assess the accuracy of the score for an individual student.

For some interest inventories, not all occupational scales will have both female and male criterion-group norms. However, providing scores on all scales, based on clearly identified female or male criterion groups, facilitates the counseling use of the inventory with all clients.

Standard 9.4

If a publisher packages tests that are to be used in combination for counseling, the counselor should review the manual for the rationale for the specific combination of tests used and the justification of the interpretive relationships among the scores. *(Primary)*

Comment:
For example, if measures of developed abilities (e.g., achievement or specific or general abilities) are used with interest measures to suggest a requisite combination of scores for success, then supporting validity data for this combination should be available.

Standard 9.5

Counselors should examine test manuals for any available information about how suggested or implied career options (i.e., the vocational program or occupation suggested by the highest scores on the test) are distributed for samples of the typical respondents of each gender and relevant racial or ethnic groups. *(Primary)*

Standard 9.6

Counselors should review the test materials that are provided to the test takers to be sure that such materials properly caution the test taker not to rely on the test scores solely when making life-planning decisions. The counselor should encourage the test taker to consider other relevant information on personal and social skills, values, interests, accomplishments, experiences, and on other test scores and observations. *(Primary)*

Comment:
It is important to recognize that vocational interests, abilities, and choices may be influenced by environmental and cultural factors, including early socialization, traditional sex-role expectations of society, and the experiences typical of members of various gender, racial, ethnic, handicapped, and socioeconomic groups. For example, female clients in general may have had fewer science- and mathematics-related experiences. Counselors in some instances may suggest and encourage exploratory experiences in those areas where interests have not had a chance to develop. For many high school students particularly, test results should be used to expand options rather than to narrow options prematurely.

Standard 9.7

Counselors should encourage multiple valid assessments of an individual's abilities, social skills, and interests. *(Primary)*

Comment:
School or work performance, extracurricular activities, and hobbies are examples of indicators that might be used to lessen a test user's and a test taker's reliance on a single measure of important characteristics.

Standard 9.8

Counselors should review the interpretive materials for ability or interest measures and for other tests that are used with people who are reentering employment or education or changing work settings for their appropriateness for these clients. A counselor should consider the age, experience, and background of the client as they are compared with the characteristics of the norm groups on which the scores are based. ***(Primary)***

Comment:
For example, for the majority of inventories and ability tests, normative data are based on younger test takers. Although these tests may be useful with older test takers, scores should be interpreted cautiously.

Standard 9.9

Counselors should review interpretive materials for tests to ensure that case studies and examples are not limited to illustrations of people in traditional roles. ***(Secondary)***

Comment:
For example, counselors might look for case studies and examples of men and women of different ages, and in different ethnic, racial, or handicapped groups. Where tests are used widely in adult counseling, such as for men and women reentering education or the labor force or changing careers, case studies and examples that are relevant for these clients should be sought.

14. Testing People Who Have Handicapping Conditions

Background

Tests are administered to people who have handicapping conditions in a variety of settings and for diverse purposes. There are a number of modifications of tests and test administration procedures that make it possible for people with certain handicapping conditions to take tests developed originally for the general population. Some modified tests, with accompanying research, have been made available by the major national testing programs for a number of years. Although the development of tests and testing procedures for such people is encouraged by the *Standards*, it should be noted that all relevant individual standards given elsewhere in this document are fully applicable to the testing applications considered in this chapter.

Some of the modifications in the way a test is administered alter the medium in which the test instructions and questions are presented to the test takers. For visually impaired people a variety of modifications may be needed. The test booklet may be produced in large print, high-quality regular print, or braille, or the test may be tape-recorded or read aloud to the test taker.

Many hearing-impaired individuals, especially the prelingually deaf, have difficulty in understanding written as well as spoken language; therefore, the intelligibility of the instructions for tests, whether written or spoken, should be considered when tests are modified for hearing-impaired test takers. Modifications of test administration for deaf and hearing-impaired people often include having an interpreter who signs or otherwise interprets the test instructions and, occasionally, the test questions.

The method used to record a response may also need to be modified. Test takers who cannot record their answers to test questions are assisted most commonly by a person who writes or marks the answers. Other ways of obtaining a response include having the respondent use a tape recorder, a typewriter, or a braillewriter. A test may have to be modified to allow a test taker to point to the response of his or her choice.

Nearly all national testing programs that provide modified test procedures for handicapped people provide additional time to take the test. Reading braille and using a cassette recorder or a reader take longer than reading regular print. Reading large type may or may not be more time consuming, depending on the layout of the material and on the nature and severity of the impairment.

Although modifications in the time allowed for tests are considered among the appropriate test options, there are few data available to support any conclusions about the effects of modifications in time, number of sittings, or number of recesses on the test results. Furthermore, little is known about how much time people with various handicapping conditions actually need because records of the time actually used are rare, and empirical studies to set time limits are even more rare.

Changes in test content are sometimes required for test takers with visual or hearing impairments. Items may be unnecessarily difficult for visually impaired people if they use visual stimuli to measure knowledge acquired through other senses. This problem can be identified and corrected by simply reviewing the items, spotting the offenders, and substituting nonvisual stimuli. Because the substitutions may alter other characteristics of the items, however, the modified items should be tried out before they are used in operational testing situations. In certain situations the test may also cause problems if it measures knowledge, skills, or concepts learned primarily through vision.

Verbal tests may create more severe problems for test takers who are prelingually deaf than for those with visual impairments. However, finding appropriate nonverbal tests to measure the same abilities or to predict the same behavior may be extremely difficult. Although this is a testing problem, it reflects more fundamental difficulties in understanding the nature of abilities, what abilities are needed in certain situations, and what existing abilities may compensate for impaired abilities in certain circumstances.

Many of the modifications in the ways tests are administered for handicapped people necessitate that the tests be given individually rather than to groups of respondents. The reasons for having an individual administration include the absence of a practical or convenient way to use a group administration, the desire not to interfere with others taking a test in a group, and the desire to reduce the anxiety handicapped people may have about the test. Some additional alterations may be required: for example, changing the location of the standard testing site if it is not accessible to people in wheelchairs; providing tables or chairs that make test takers with certain physical disabilities more comfortable; and altering lighting conditions and associated space needs for people with some visual impairments.

Despite the history of attempts to modify tests for handicapped people, significant problems remain. First, there have been few empirical investigations of the effects of special accommodations on the resulting scores or on their reliability and validity. Strictly speaking, unless it has been demonstrated that the psychometric properties of a test, or type of test, are not altered significantly by some modification, the claims made for the test by its author or publisher cannot be generalized to the modified version. The major reason for the lack of research is the relatively small number of handicapped test takers. For example, there are usually not enough students with handicapping conditions entering one school in any given year to conduct the type of validation study that is usually conducted for college admission tests.

Although modifying tests for individuals with handicapping conditions is generally regarded as desirable, sometimes some very basic, unanswered questions should be confronted. When tests are administered to people with handicapping conditions, particularly those handicaps that affect cognitive functioning, a relevant question is whether the modified test measures the same constructs. Do changes in the medium of expression affect cognitive functioning and the meaning of responses?

Of all the aspects of testing people who have handicapping conditions, reporting test scores has created the most heated debate. Many test developers have argued that reporting scores from nonstandard test administrations without special identification (often called "flagging" of test scores) violates professional principles, misleads test users, and perhaps even harms handicapped test takers whose scores do not accurately reflect their abilities. Handicapped people, on the other hand, have generally said that to identify their scores as resulting from nonstandard administrations and in so doing to identify them as handicapped is to deny them the opportunity to compete on the same grounds as nonhandicapped test takers, that is, to treat them inequitably. Until test scores can be demonstrated to be comparable in some widely accepted sense, there is little hope of happily resolving from all perspectives the issue of reporting scores with or without special identification. Professional and ethical considerations should be weighed to arrive at a solution, either as an interim measure or as continuing policy.

Standard 14.1

People who modify tests for handicapped people should have available to them psychometric expertise for so doing. In addition, they should have available to them knowledge of the effects of various handicapping conditions on test performance, acquired either from their own training or experience or from close consultation with handicapped individuals or those thoroughly familiar with such individuals. *(Primary)*

Standard 14.2

Until tests have been validated for people who have specific handicapping conditions, test publishers should issue cautionary statements in manuals and elsewhere regarding confidence in interpretations based on such test scores. *(Primary)*

Standard 14.3

Forms of tests that are modified for people who have various handicapping conditions should generally be pilot tested on people who are similarly handicapped to check the appropriateness and feasibility of the modifications. *(Conditional)*

Comment:
Although useful guides to modifying tests are available, they do not provide a universal substitute for trying out a modified test or validating the modified version of a test. Even when such tryouts are conducted on samples inadequate to produce norm or validity data, they should be conducted to check the mechanics of the modifications.

Standard 14.4

Interpretive information that accompanies modified tests should include a careful statement of the steps taken to modify tests in order to alert users to changes that are likely to alter the validity of the measure. *(Conditional)*

Comment:
If empirical evidence of the nature and effects of changes resulting from modifying standard tests is lacking, it is impossible to enumerate significant modifications that are to be documented in manuals. Therefore, test developers should take care to document all changes made and be alert to indications of possible effects of those modifications. Documentation of the procedure used to modify tests will not only aid in the administration and interpretation of the given test but will also inform others who are modifying tests for people with specific handicapping conditions.

Standard 14.5

Empirical procedures should be used whenever possible to establish time limits for modified forms of timed tests rather than simply allowing handicapped test takers a multiple of the standard time. Fatigue should be investigated as a potentially important factor when time limits are extended. *(Secondary)*

Standard 14.6

When feasible, the validity and reliability of tests administered to people with various handicapping conditions should be investigated and reported by the agency or publisher that makes the modification. Such investigations should examine the effects of modifications made for people with various handicapping conditions on resulting scores, as well as the effects of administering standard unmodified tests to them. ***(Secondary)***

Comment:
In addition to modifying tests and test administration procedures for people who have handicapping conditions, validating these tests is urgently needed. Validation is the only way to amass knowledge about the usefulness of tests for people with handicapping conditions. The costs of validating these tests should be weighed against those of not having usable information regarding the meanings of scores for handicapped people.

Standard 14.7

Those who use tests and those who interact professionally with potential test takers with handicapping conditions (e.g., high school guidance counselors) should (a) possess the information necessary to make an appropriate selection of alternate measures, (b) have current information regarding the availability of modified forms of the test in question, (c) inform individuals with handicapping conditions, when appropriate, about the existence of modified forms, and (d) make these forms available to test takers when appropriate and feasible. ***(Primary)***

Standard 14.8

In assessing characteristics of individuals with handicapping conditions, the test user should use either regular or special norms for calculating derived scores, depending on the purpose of the testing. Regular norms for the characteristic in question are appropriate when the purpose involves the test taker's functioning relative to the general population. If available, however, special norms should be selected when the test takers' functioning relative to their handicapped peers is at issue. ***(Primary)***

15. Test Administration, Scoring, and Reporting

Background

Interpretations of test results, like those of experimental results, are most reliable when the measurements are obtained under standardized or controlled conditions. Without standardization, the quality of interpretations will be reduced to the extent that differences in procedure influence performance. To be sure, in some circumstances testing conditions may be changed systematically in order to improve the understanding of an individual's performance. Accurate scoring and reporting are essential in all circumstances. Computerized test administration and reporting can introduce some special difficulties.

Standard 15.1

In typical applications, test administrators should follow carefully the standardized procedures for administration and scoring specified by the test publisher. Specifications regarding instructions to test takers, time limits, the form of item presentation or response, and test materials or equipment should be strictly observed. Exceptions should be made only on the basis of carefully considered professional judgment, primarily in clinical applications. ***(Primary)***

Standard 15.2

The testing environment should be one of reasonable comfort and with minimal distractions. Testing materials should be readable and understandable. In computerized testing, items displayed on a screen should be legible and free from glare, and the terminal should be properly positioned. ***(Primary)***

Comment:
Testing sessions should be monitored where appropriate both to assist the test taker when a need arises and to maintain proper administrative procedures. Noise, disruption in the testing area, extremes of temperature, inadequate work space, illegible materials, and so forth are among the conditions that should be avoided in testing situations. In the context of computer-administered tests, the novelty of the presentation may have an unknown effect on the test administration.

Standard 15.3

Reasonable efforts should be made to assure the validity of test scores by eliminating opportunities for test takers to attain scores by fraudulent means. ***(Primary)***

Comment:
In large-scale testing programs where the results may be viewed as having important consequences, these efforts should include, when appropriate and practicable, simultaneous administration to all individuals taking the same form, stipulating requirements for identification, constructing seating charts, assigning test takers to seats, requiring appropriate space between seats, and providing continuous monitoring of the testing process. Test administrators should note and report any significant instances of testing irregularity.

Standard 15.4

In school situations not involving admissions and in clinical and counseling applications, any modification of standard test administration procedures or scoring should be described in the testing

reports with appropriate cautions regarding the possible effects of such modifications on validity. ***(Primary)***

Standard 15.5

Test scoring services should document the procedures that were followed in order to assure accuracy of scoring. The frequency of error should be monitored and reported on request. ***(Conditional)***

Standard 15.6

When the score report may be the basis on which decisions would be made in the near future and a material error is found in test scores or other important information released by a testing organization or other institution, a corrected score report should be distributed as soon as it is practicable. ***(Primary)***

Standard 15.7

Test users should protect the security of test materials. ***(Primary)***

Comment:
Those who have test materials under their control should take all steps necessary to assure that only individuals with a legitimate need for access to test materials are able to obtain such access.

Standard 15.8

In educational admissions and licensing or certification applications, in which important decisions depend on performance on a given test, a means of checking the accuracy of the scoring should be available to test takers. When the test itself and the scoring key cannot be released, some other means of verification should be provided. ***(Conditional)***

Standard 15.9

When test data about a person are retained, both the test protocol and any written report should also be preserved. ***(Primary)***

Standard 15.10

Those responsible for testing programs should provide appropriate interpretations when test score information is released to students, parents, legal representatives, teachers, or the media. The interpretations should describe in simple language what the test covers, what scores mean, common misinterpretations of test scores, and how scores will be used. ***(Primary)***

Comment:
Test users should consult the interpretive material prepared by the test developer or publisher and should revise or supplement the material as necessary to present the local and individual results accurately and clearly.

Standard 15.11

Organizations that maintain test scores on individuals in data files or in an individual's records should develop a clear set of policy guidelines on the duration of retention in an individual's records, availability, and use over time of such scores. ***(Primary)***

Comment:
In some instances test scores become obsolete over time and should not be used or be available. In other cases test scores obtained in past years can be extremely useful, for example, in longitudinal assessment. The key issue is the valid use of the information.

16. Protecting the Rights of Test Takers

Background

Certain broad principles regarding access to test scores are now widely accepted. Some technical requirements necessary to satisfy these principles are stated as specific standards in this chapter. The issues of test security and the cancellation of test takers' scores because of testing irregularities are also addressed.

Standard 16.1

Informed consent should be obtained from test takers or their legal representatives before testing is done except (a) when testing without consent is mandated by law or governmental regulation (e.g., statewide testing programs); (b) when testing is conducted as a regular part of school activities (e.g., schoolwide testing programs and participation by schools in norming and research studies); or (c) when consent is clearly implied (e.g., application for employment or educational admissions). When consent is not required, test takers should be informed concerning the testing process. *(Primary)*

Comment:
Informed consent implies that the test takers or representatives are made aware, in language that they can understand, of the reasons for testing, the type of tests to be used, the intended use and the range of material consequences of the intended use, and what testing information will be released and to whom. When law mandates testing but does not require informed consent, test users should exercise discretion in obtaining informed consent, but test takers should always be given relevant information about a test when it is in their interest to be informed.

Young test takers should receive an explanation of the reasons for testing. Even a child as young as two or three and many mentally retarded test takers can understand a simple explanation as to why they are being tested. For example, an explanation such as "I'm going to ask you to try to do some things so that I can see what you know how to do and what things you could use some more help with" would be understandable to such test takers.

Standard 16.2

In school, clinical, and counseling applications, test users should provide test takers or their legal representative with an appropriate explanation of test results and recommendations made on the basis of test results in a form that they can understand. *(Primary)*

Comment:
This standard requires both the use of the appropriate language with non-English speaking test takers and the use of conceptually understandable explanations with all types of test takers. Even children and many mentally retarded test takers can understand a simple explanation of test results.

Standard 16.3

Test results identified by the names of individual test takers should not be released to any person or institution without the informed consent of the test taker or an authorized representative unless otherwise required by law. Scores of individuals identified by name should be made

available only to those with a legitimate, professional interest in particular cases. ***(Primary)***

Comment:
Information may be provided to researchers if a test taker's anonymity is maintained and the intended use is not inconsistent with the conditions of the test taker's informed consent.

Standard 16.4

In educational, clinical, and counseling applications, when test scores are used to make decisions about individuals, the affected person or legal representative should be able to obtain transmittal of this test score and its interpretation for any appropriate use. ***(Secondary)***

Standard 16.5

Test data maintained in data files should be adequately protected from improper disclosure. Use of time-sharing networks, data banks, and other electronic data processing systems should be restricted to situations in which confidentiality can be reasonably assured. ***(Primary)***

Standard 16.6

When score reporting includes assigning individuals to categories, the categories chosen should be based on carefully selected criteria. The least stigmatizing labels, consistent with accurate reporting, should always be assigned. ***(Primary)***

Standard 16.7

Under certain conditions it may be desirable to cancel a test taker's score or to withhold it because of possible testing irregularities, including suspected misconduct. The type of evidence and procedures to be used to determine that a score should be canceled or withheld should be explained fully to all test takers whose scores are being withheld or canceled. ***(Primary)***

Standard 16.8

In educational admissions and licensing and certification applications, when a score report will be delayed beyond a brief investigative period because of possible irregularities such as suspected misconduct, the test taker should be notified, the reason given, and reasonable efforts made to expedite review and to protect the interests of the test taker. ***(Primary)***

Standard 16.9

In educational admissions and licensing and certification applications, before a score is canceled or its report is withheld beyond a brief investigative period, test takers should be given advance warning and an opportunity to provide evidence that the score should not be canceled or withheld. All evidence considered in deciding upon the intended action, including evidence that might lead to a contrary decision, should be made available to the test taker on request. ***(Primary)***

Comment:
Some testing organizations offer the option of a prompt and free retest or arbitration of disputes.

Standard 16.10 **In educational admissions and licensing and certification applications, when testing irregularities are suspected, all available data judged to be relevant should be considered.** ***(Primary)***

Comment:
Allegations of testing irregularity that involve copying are sometimes based on a comparison of the distractors chosen by two test takers on items answered incorrectly by both. This method should not be used as the sole basis for decisions since it ignores other evidence that might indicate that copying did not take place. Reasonable efforts should be made to obtain contrary, as well as supporting, evidence to settle the matter of irregularity as well as the validity of the questioned score.

INTERNSHIP REQUIREMENTS

CLINICAL INTERNSHIPS
PSYCHIATRIC REHABILITATION

Full-time paid, 6 month clinical internships in Psychiatric-Vocational Rehabilitation will be offered each year for three years to students completing their Master's program in Rehabilitation Counseling. Internships are located within the Neuropsychological Assessment and Rehabilitation Services Program, Western Psychiatric Institute and Clinic/Presbyterian University Hospital. While the six month clinical internships are geared toward master's level students in their final semester of academic coursework at various universities throughout the country and Puerto Rico, there may be staff in the field who would opt for such a supervised field work experience. Stipends total $800 per month.

Internship experience will include:

- **administration and interpretation of vocational and psychoeducational test batteries**
- **conducting career counseling and vocational exploration on an individual and group basis**
- **providing job seeking skills training and job coaching for selected clients/patients involved in transitional and supported employment**
- **exposure to and involvement in job development activities**
- **liaison work with the local VR agency**
- **attendance at formal lecture series on the Principles of Psychiatric Rehabilitation**
- **participation in ongoing clinical research studies**
- **involvement with advocacy and consumer groups**

Credits earned for the internship experience will be determined by the student's college or university program. Students will be paid for their work at the internship site and in all cases will have agreed to a year's commitment pay-back at a qualifying rehabilitation agency or facility.

Training will be conducted in facilities that are architecturally barrier free and accessible. When appropriate and necessary, accommodations will be made for participants with special needs. All application materials will provide individuals with the opportunity to indicate needs for special assistance and services.

If interested, please write or call for Application materials:

Lynda J. Katz, Ph.D.
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213
(412) 624-2197

University of Pittsburgh
Medical Center

Western Psychiatric Institute and Clinic

204 Iroquois Building
3600 Forbes Avenue
Pittsburgh, PA 15213-3410
412-624-2842

**Psychiatric Rehabilitation and
Assessment Services**

Dear Applicant:

Enclosed please find an application form for the Clinical Internship Training Program in Psychiatric/Vocational Rehabilitation which is being sponsored by the Psychiatric Rehabilitation and Assessment Services Department of Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center, under the direction of Michelle Geckle, M.Ed., CRC.

Each year (for 3 years) a total of six students will be accepted into the internship program. Therefore, in Year 03 (1995-1996), three students will be accepted to begin in August, 1995 and three students will be accepted to begin in February, 1996. For those of you applying for August, 1995 enrollment, application materials are due June 2, 1995. For those of you applying for February, 1996 enrollment, application materials are due October 30, 1995.

Listed below is the Registration Process. Please follow these instructions carefully.

1. Complete the enclosed Application Form.
2. Send a copy of your undergraduate and graduate transcripts.
3. Send two (2) letters of reference. These may be obtained from an academic program faculty member and/or Practicum Supervisor.
4. Send all materials to:

Michelle Geckle, M.Ed., CRC
PRAS/WPIC
3811 O'Hara Street
Pittsburgh, PA 15213

If you have any questions regarding the registration process, please do not hesitate to call me at (412) 624-2842.

Sincerely,

Michelle Geckle, M.Ed., CRC
Program Director

INTERNSHIP
APPLICATION FORM

(Please print or type the following information.)

Last Name: ______________________ First Name: ______________ Middle Initial: ____

Soc.Sec. #: ___-__-___ Date of Birth: _/_/__ Sex: _Male _Female Race: _____ Disability: __ Yes __ No

Home Address: ____

____

Home Phone: (____) _____-________

Work Address: ____

____

Work Phone: (____) _____-________

University Advisor ____

Practicum Experience

1) Agency Name: ______________________________ From _______ To ______

Agency Supervisor: ______________________________

Major Responsibilities: ____

2) Agency Name: ______________________________ From _______ To ______

Agency Supervisor: ______________________________

Major Responsibilities: ____

3) Agency Name: ______________________________ From _______ To ______

Agency Supervisor: ______________________________

Major Responsibilities: ____

Education

a. High School	Diploma Cert.	Degree	Year attained	Major Field of Study
b. College or Technical School 1) 2) 3)				
c. Post Baccalaureate 1) 2) 3)				

Previous Employment

Job Title: ______________________ Years in this position __________

Agency name: ______________________

Agency supervisor: ______________________

Specify job functions and responsibilities: ______________________

____

____

____

Special Needs

__________ READER SERVICES

__________ CASSETTE TAPES

__________ INTERPRETER SERVICES

__________ OTHER (PLEASE SPECIFY) ____________________

____

____

____

__________ NONE REQUIRED

___ I AM APPLYING FOR SEPTEMBER, 1993 ENROLLMENT. (DUE DATE JULY 1, 1993)

___ I AM APPLYING FOR MARCH, 1994 ENROLLMENT. (DUE DATE OCTOBER 30, 1993)

PLEASE RETURN FORMS TO:

LYNDA J. KATZ, PH.D.
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
3811 O'HARA STREET
PITTSBURGH, PA 15213

FILE COPY

January 2, 1996

Lori Kroeger
2495 Rocky Hollow Lane
Deatsville, AL 36022

Dear Ms. Kroeger:

You have been selected to enter the Rehabilitation Services Administration (RSA) funded "Clinical Internship Training Program in Psychiatric Vocational Rehabilitation" at Western Psychiatric Institute and Clinic. Your internship is scheduled to begin Monday, February 19, 1996, and will continue until Monday, August 19, 1996. Please report to the Psychiatric Rehabilitation and Assessment Services clinic, 505 Iroquois Building, 3600 Forbes Avenue, at 8:30 a.m. on Monday, February 19, 1996. Clinic hours are 8:30 a.m. - 5:00 p.m., Monday through Friday. You will be paid a stipend of $897 per month for your internship.

As an RSA scholarship recipient, you are required to "payback" your assistance through employment in a State rehabilitation agency or nonprofit or related facility or agency providing services under an agreement with a state rehabilitation agency. You must sign an agreement with the University of Pittsburgh, which states that you are required to work not less than two years for each year of RSA support. As a clinical internship student you will receive 6 months of support, therefore your payback time will be 12 months or one year. If you do not work for one of the approved types of agencies, you will be required to repay the RSA funds that you received.

We are very pleased that you have been chosen for this award and look forward to having you with us.

Sincerely,

Michelle Geckle, M.Ed., CRC
Project Director,
Clinical Internship Supervisor

/jd

CLINICAL INTERNSHIP TRAINING PROGRAM IN PSYCHIATRIC VOCATIONAL REHABILITATION
RSA GRANT No. H129H30003

AGREEMENT

This agreement is made and entered on this 22, August 1995 by and between the University of Pittsburgh and its Rehabilitation Services Administration Clinical Internship Training Program in Psychiatric Vocational Rehabilitation and its scholarship recipients. As required by the Code of Federal Regulations Title 34, Part 386, Section 4, the following agreement is in effect.

I Linda Karen Criss understand that:

(1) Within the ten-year period after cessation of my enrollment in the course of study for which my scholarship was awarded, I Linda Karen Criss will obtain and maintain employment in a State rehabilitation agency providing services to individuals with handicaps under an agreement with a State agency or in a non-profit rehabilitation or related agency providing services to individuals with handicaps under an agreement with a State agency. My obligation is based on the established formula that for each academic year for which a scholarship is received, I will pay back in employment, two years. I have received a scholarship for six months, therefore my employment obligation is for one year.

(2) I understand that until I have satisfied the employment obligation as described in Provision 1, I will inform the Project Director of this RSA funded long term training grant (Michelle Geckle, M.Ed., CRC, or her designee) of any change of name, address or employment status and I will document employment satisfying the terms of the agreement.

(3) I also understand that subject to the provisions in Section 386.45 regarding a waiver of deferral, when I enter repayment status under Section 386.47 (e) of the program regulations, the amount of the scholarship that has not been retired through eligible employment will constitute a debt owed the United States that:

(a) Will be repaid by me, including interest and costs of collection as provided in Section 386.47 of the program regulations; and

(b) May be collected by the Secretary in accordance with 34 CFR Part 30, in the case of my failure to meet the obligation of Section 386.47 of the program regulations.

I have read and agree to the above contract.

Project Director,
RSA Clinical Internship Training Program
in Psychiatric Vocational Rehabilitation,
School of Health and Rehabilitation Sciences,
University of Pittsburgh

BY: Michelle Geckle M.Ed. CRC
Michelle Geckle, M.Ed., CRC

DATE: 8-22-95

Scholarship Recipient

BY: Linda Karen Criss

DATE: 8/22/95

WPIC STUDENT REGISTRATION

Name of Student(s): Linda Karen Empfield -Criss

If a group of students will be engaged in identical activities, one form may be used. Please attach a list of names.

College or University: West Virginia University Department: Rehabilitation Counseling

Degree Sought By Student(s):

Undergraduate: Associate ______ Bachelor's ______

Graduate: Master's M.S. Ph.D. ______

Year of Expected Graduation: 1995

Other (Please Specify) ______

WPIC Program Placement: Psychiatric Rehabilitation and Assessment Services (PRAS)

Dates of Placement: 8-22-95 to 2-16-96

WPIC Supervisor: Michelle Geckle, M.Ed., CRC

Brief Description of Student Activity: (Where possible, include number of hours per week expected of student.)

Internship experience will include:

- administration and interpretation of vocational and psychoeducational test batteries
- conducting career counseling and vocational exploration on an individual and group basis
- providing job seeking skills training and job coaching for selected clients/patients involved in transitional and supported employment
- exposure to and involvement in job development activities
- liaison work with the local VR agency
- attendance at formal lecture series on the Principles of Psychiatric Rehabilitation
- participation in ongoing clinical research studies
- involvement with advocacy and consumer groups
- one hour individual and two hour group supervision per week

PLEASE RETURN THIS FORM TO THE OFFICE OF VOLUNTEER AND STUDENT SERVICES, ROOM 126, WPIC.

Reviewed 5/94

WPIC STUDENT AGREEMENT

Having entered into an agreement for a student placement at Western Psychiatric Institute and Clinic, I understand that I am expected to function under the guidelines and/or limitations described by my supervisor, follow all WPIC rules and regulations and meet regularly with my supervisor. I agree to treat as confidential any information or data which is obtained during my stay at WPIC.

If performance evaluations are completed by my WPIC supervisor, I will be afforded the opportunity to review these evaluations and to consent to their release to other persons or agencies requesting them.

I have had a physical examination within the past year and have no communicable disease including tuberculosis, nor any other health condition which will significantly affect my performance as a student. I understand that WPIC has no responsibility for my health care except to provide for emergency treatment in the event of an accident while at the Institute. I will be financially responsible for such care.

I understand that Western Psychiatric Institute and Clinic is in no way liable for any claims or demands resulting from any act or ommission on my part related to my training placement at WPIC. It is my personal responsibility or that of the academic institution in which I am enrolled to carry professional liability insurance against such claims.*

I understand that the perception of patients and the public are affected by appearance. When working in a clinical setting at WPIC, I will dress in accordance with a professional appearance and will not wear leisure clothing such as blue jeans, sweat shirts, T-shirts, etc.

Failure to comply with WPIC student policies may be cause for dismissal from the WPIC student placement.

Linda Karen [illegible]-Criss
Student Signature

West Virginia University
University or College

Rehabilitation - Psychiatric Disabilities
Field of Study

Psychiatric Rehab. Services
WPIC Program Placement

8-22-95 to 2-16-96
Dates of Placement

IN CASE OF EMERGENCY, NOTIFY Don Criss PHONE 292-6207 Home
293-5603 ext 50 Office

* The request for professional liability insurance is not applicable to University of Pittsburgh students.

University of Pittsburgh
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

TO: Program Directors
Faculty Supervisors

FROM: Susan Erstling, M.S.W., Ph.D.
Director, Volunteer and Student Services

DATE: August 18, 1993

RE: Registration of trainees and students for Fall 1993 academic term

Registration is necessary for all clinical students and trainees (except University of Pittsburgh medical students or work-study students) who will be placed at WPIC. Registration and agreement forms to be used are attached.

Please send students such as Masters level trainees, social work, special education, pharmacy and nursing students with completed forms to the Office of Volunteer and Student Services, 2nd floor, WPIC. We will inform trainees of responsibilities including:

1. How to obtain a TB test
2. OSHA requirements regarding Fire Safety and Universal Precautions
3. How to obtain an I.D. badge
4. How to obtain a clinic key

All other students (e.g. undergraduates) should come to our office to fill out an application regardless of whether or not they plan to earn credit. The attached agreement does not apply to them. We will inform undergraduates and other students about the TB test, ID badge and orientation about WPIC policies and OSHA requirements.

CONTRACTS

Before a student can be accepted for internship at WPIC, we must have a signed student training contract with his/her college or university. Over the years WPIC has entered into contractual agreements with most of the schools in the area, plus several from further afield. Please call 624-2145 as to the status of any school if you are not sure a contract has been signed, and we will facilitate this process if necessary.

Thank you for your cooperation.

[illegible] STREET, PITTSBURGH, PA 15213-2593

LETTER OF AGREEMENT BETWEEN

____

AND

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
OF PRESBYTERIAN UNIVERSITY HOSPITAL

THIS AGREEMENT is between ______________________________ and WESTERN PSYCHIATRIC INSTITUTE AND CLINIC OF PRESBYTERIAN UNIVERSITY HOSPITAL (hereinafter referred to as WPIC). The parties agree that WPIC will receive students of the ________________________ Department of ______________________________ for the mutual goal of training students.

(Please include brief statement of the goals of the student placement)

THIS AGREEMENT will commence on ____________________, and will continue indefinitely (OR will terminate on ____________________), unless terminated sooner by either party with thirty (30) days written notice.

Therefore it is understood and agreed between the parties that the responsibilities of ______________________________ shall be:

1. Provide WPIC with a statement of the current curriculum and course objectives of the students placed at WPIC.

2. Indemnify and hold harmless, WPIC, its officers, directors, agents and employees from and against any and all claims, demands and liabilities for personal injuries, deaths or damage to property arising out of any act or omission of any student.

   NOTE: If the Institution maintains liability insurance for students or requires that students provide for personal liability coverage, a statement to that effect, including the extent of coverage should be added.

3. Advise students that WPIC requires that they be in good health and have had a physical examination within the past year including a tuberculin skin test.

4. Advise students that they are responsible for the costs of their health care including emergency treatment for any accident sustained during their WPIC placement.

5. Advise students of their responsibility to comply with the rules and regulations of WPIC.

6. Advise students of their responsibility to respect the confidential nature of all information which they may obtain during the course of their student placement at WPIC.

Responsibilities of WPIC:

1. Provide the assigned students with the opportunity to pursue the goals defined above.

2. Provide staff supervision consistent with the above goals.

3. Render emergency medical care or triage to any student or supervising faculty for any injury or sudden illness occurring during the course of a work related activity, the cost of which will be borne by the injured party.

4. Evaluate the performance of the student according to the requirements of ______________________________.

5. Retain the right to reject or terminate the student placement for failure to meet the standards of the WPIC program or for a breach of WPIC rules and regulations.

WESTERN PSYCHIATRIC INSTITUTE
AND CLINIC OF PRESBYTERIAN
UNIVERSITY HOSPITAL

____
____

BY: ______________________________
John W. Paul
Chief Financial Officer

BY: ______________________________

DATE: ______________________________

DATE: ______________________________

10/93

LETTER OF AGREEMENT
BETWEEN
THE UNIVERSITY OF PUERTO RICO
AND
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC OF PRESBYTERIAN UNIVERSITY HOSPITAL

THIS AGREEMENT is between the UNIVERSITY OF PUERTO RICO AND WESTERN PSYCHIATRIC INSTITUTE AND CLINIC OF PRESBYTERIAN UNIVERSITY HOSPITAL (hereinafter referred to as WPIC). The parties agree that WPIC will receive students of the Master's Degree level in the School of Rehabilitation Counseling for the mutual goal of training students.

The goals of student placement may be summarized as follows:

1. To become acquainted with mental health and vocational rehabilitation service delivery systems for persons with mental disabilities.

2. To become acquainted with diagnostic and vocational assessment procedures utilized in the rehabilitation of persons with mental disabilities.

3. To become acquainted with the development and implementation of individualized vocational rehabilitation plans for persons with mental disabilities.

4. To become acquainted with the facilitation of the rehabilitation process of persons with mental disabilities, including both direct and indirect services such as individual and group vocational counseling, educational, training, and rehabilitation intervention, consultation, and referral, and identification of community resources and services coordination.

5. To become acquainted with the integration of counseling theories and skills in the process psychiatric vocational rehabilitation with persons with mental disabilities.

6. To become acquainted with the working of an interdisciplinary team throughout the vocational rehabilitation process with persons with mental disabilities.

7. To become acquainted with the knowledge bases in the area of psychiatric disabilities, including mental illness, treatment, rehabilitation strategies, and research.

This agreement will commence on September 1, 1993, and will continue indefinitely unless terminated sooner by either party with 30 days written notice.

Therefore, it is understood and agreed between the parties that the responsibilities of the University of Puerto Rico shall be:

1. Provide WPIC with a statement of the current curriculum and course objectives of the students placed at WPIC.

2. Indemnify and hold harmless, WPIC, its officers, directors, agents and employees from and against any and all claims, demands and liabilities for personal injuries, deaths or damage to property arising out of any act or omission of any students. (See Certificate of Insurance attached: Policy No. CRP 2107609, covering the period from 06-01-93 to 06-01-94.

3. Advise students that WPIC requires that they be in good health and have had a physical examination within the past year including a tuberculin skin test.

4. Advise students that they are responsible for the costs of their health care, including emergency treatment for any accident sustained during their WPIC placement.

5. Advise students of their responsibility to comply with the rules and regulations of WPIC.

6. Advise students of their responsibilities to respect the confidential nature of all information to which they may be exposed during the course of their student placement at WPIC.

Responsibilities of WPIC:

1. Provide the assigned students with the opportunity to pursue the goals defined above.

2. Provide staff supervision consistent with the above goals.

3. Render emergency medical care or triage to any student or supervising faculty for any injury or sudden illness occurring during the course of a work related activity, the cost of which will be borne by the injured party.

4. Evaluate the performance of the student according to the requirements of the University of Puerto Rico.

5. Retain the right to reject or terminate the student placement for failure to meet for failure to meet the standards of the WPIC program or for a breach of WPIC rules and regulations.

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC PRESBYTERIAN UNIVERSITY HOSPITAL		UNIVERSITY OF PUERTO RICO
BY:	______________________	______________________ Efraín González Tejera
DATE:	______________________	______________________

8/1993

CERTIFICATE OF INSURANCE

ISSUE DATE (MM/DD/YY)
4/26/90

PRODUCER

[illegible] CONFERS NO [illegible] NOT AMEND, EX- [illegible] BELOW

[illegible] E DIAMOND ST
MORGAN CTR SUITE
BUTLER PA 16001

CODE SUB CODE

INSURED

MERCYHURST COLLEGE CORP
501 E 38TH ST
ERIE PA 16504

COMPANIES AFFORDING COVERAGE

A	MARYLAND CASUALTY CO
B	
C	FIREMENS FUND INS CO
D	
COMPANY LETTER E	

COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD IN- [illegible] CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN. THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	ALL LIMITS **IN THOUSANDS**	
A	GENERAL LIABILITY	EPA06766910	7/01/89	7/01/90	GENERAL AGGREGATE	2,000
	X COMMERCIAL GENERAL LIABILITY				PRODUCTS-COMP/OPS AGGREGATE	
	CLAIMS MADE X OCCUR.				PERSONAL & ADVERTISING INJURY	2,000
	OWNER'S & CONTRACTOR'S PROT.				EACH OCCURRENCE	2,000
					FIRE DAMAGE (Any one fire)	50
					MED. EXPENSE (Any one person)	5
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT	
	ANY AUTO				BODILY INJURY (Per person)	
	[illegible]				BODILY INJURY [illegible]	
	[illegible]				PROPERTY DAMAGE	
C	EXCESS LIABILITY	X0K2126890	7/01/89	7/01/90	EACH OCCURRENCE 1,000	AGGREGATE 1,000
	X					
	WORKER'S COMPENSATION AND EMPLOYERS' LIABILITY				STATUTORY	
					EACH ACCIDENT	
					DISEASE—POLICY LIMIT	
					DISEASE — EACH EMPLOYEE	
	OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/RESTRICTIONS/SPECIAL ITEMS

COLLEGE

BEST COPY AVAILABLE

CERTIFICATE HOLDER Susan Erstling, MSW, Ph.D.

DIRECTOR OF EDUCATIONAL SUPPORT &
V[illegible]TEER SERVICES
UNIVERSITY OF PITTSBURGH
WESTERN PSYCHIATRIC INSTITUTE & CLINIC
3811 O'HARA ST. (Room 208)
PITTSBURGH, PA. 16213-2593

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

SUSAN D. MA[illegible] BA

© ACORD CORPORATION 1989 THIS IS A VARIATION OF ACORD FORM 25S AND IS IN [illegible] WARNING: THIS FORM IS NOT COMPATIBLE WITH ALL SOFTWARE PROGRAMS

NAME: Chris Leno Weekly Schedule WEEK OF: 1/[illegible]/96

	MONDAY 1/29	TUESDAY 1/30	WEDNESDAY 1/31	THURSDAY 2/1	FRIDAY 2/2
8:30 a.m.	Prepared for sessions ↓	↓			
9:00 a.m.	Individual session - Chulack	Borderline Personality Video ↓	Gave blood ↓	Wrote contacts Read new Partial sched	Domestic Violence Inservice
10:00 a.m.	Wrote contact sheet	Prepared for session	Prepared for session	Scored CAPS Thompson	
11:00 a.m.	Individual Session - Arthur ↓	Individual session - Chodoch ↓	Individual session - Henry ↓	Scored CAPS - Evan	
12:00 noon	Lunch	Lunch	Lunch	Lunch ↓	↓
1:00 p.m.	Wrote contact sheet Prepared sheets - scoring	Individual session - Thompson ↓	Individual session - Eva	Plotted CAPS on graphs	Lunch
2:00 p.m.	CLAC non-cl. sched ALEX	Prepared for session	Recopied [redacted] contact sheet	Score - MSEI [redacted] Letters to pts	Set up camera - prepare [redacted] Individual session
3:00 p.m.	Job opp. Read on BPD ↓	Individual Session - Rush ↓	Tx plan - Eva	Registered (me/new interns) for dev. Job leads ↓	- Kelly ↓
4:00 p.m.	Recopied contact sheets	wrote contact sheets			Camera, ALEX ↓
5:00 p.m.					

NOTES/COMMENTS:

UNIVERSITY OF PITTSBURGH
REHABILITATION COUNSELING PROGRAM

Counselor Evaluation Form - Masters

NAME OF COUNSELOR ______________________________ DATE __________

SUPERVISOR ____________________________ AGENCY ________________

LEVEL: Practicum/Internship ________ ADVISOR: ____________________

Below are statements reflecting some of the important areas of knowledge and skill that are necessary to function effectively as a professional rehabilitation counselor. We realize that not all agencies can provide students with an opportunity to engage in all of these rehabilitation tasks, and thus one or more items may not be applicable to a particular agency. Please rate the counselor's performance in those rehabilitation tasks that are appropriate to your agency, compared with other counselors at this level of training and experience that you have supervised. Use the space beneath each item to make specific recommendations or to provide further comment.

Please review evaluations with your student(s) at mid-term and at the end of the term.

	N.A.	Poor	Average	Above Average	Excellent
Is knowledgeable about counseling theories?	0	1	2	3	4
Comment:					
Is able to demonstrate counseling skills (please indicate if student engaged in group and/or family counseling)?	0	1	2	3	4
Comment:					
Function in a professional manner within the agency?	0	1	2	3	4
Comment:					

	N.A.	Poor	Average	Above Average	Excellent
Function in supervisory/administrative capacity	0	1	2	3	4
Comment:					
Apply principles and techniques of psychological and vocational assessment?	0	1	2	3	4
Comment:					
Utilize community resources?	0	1	2	3	4
Comment:					
Demonstrate knowledge of medical, psychological and vocational aspects of physical and mental disabilities?	0	1	2	3	4
Comment:					
Conduct vocational counseling, job development and placement with clients?	0	1	2	3	4
Comment:					
Prepare written and deliver verbal reports?	0	1	2	3	4
Comment:					
Demonstrate initiative and willingness to increase his/her skills as a rehabilitation counselor?	0	1	2	3	4
Comment:					

	NA	Poor	Average	Above Average	Excellent
Compared with all other rehabilitation counselors that you have worked with at this level of training and experience, how would you rate this counselor overall?	0	1	2	3	4

Student signature*

Supervisor's signature

Advisor's signature

ADDITIONAL COMMENTS:

*Student cannot be assigned a grade without the necessary signatures from student, supervisor, and university advisor.

PRACTICUM/INTERNSHIP PERFORMANCE EVALUATION FORM

Rehabilitation Counseling Concentration

Name of Student ____________________________
Report of performance observed from __________ to __________

PART I - Specific Competencies

Below is a list of the competencies required of the Rehabilitation Counselor identified in the 1991 standards set by the Council on Rehabilitation Education (CORE). In evaluating the progress of a Rehabilitation Counselor practicum or internship student the student's level of skills and knowledge in each area listed should be assessed on the scale provided.

Student's current level of performance
- Excellent - needs little or no supervision
- Good - understands what is required but needs continued practice or supervision
- Poor - needs more knowledge and training and more practice under supervisor
- N/A - no opportunity to observe student in this area

Competency Areas

1.0 Program graduates shall satisfactorily practice rehabilitation counseling in a legal and ethical manner and show understanding of the history, philosophy, and structure of the rehabilitation delivers systems in the United States. Tasks typically include the ability to:

	EXCELLENT	GOOD	POOR	N/A
1.1 apply ethical principles and standards;				
1.2 apply appropriate legal principles and utilizes ethical decision making skills in resolving ethical dilemmas;				
1.3 demonstrate knowledge of the history, philosophy, and legislation affecting rehabilitation and the scope of services of various service delivery systems.				

2.0 Program graduates shall satisfactorily practice rehabilitation counseling with individuals, groups, and/or families. Tasks typically include the ability to:

		EXCELLENT	GOOD	POOR	N/A
2.1	conduct individual counseling sessions;				
2.2	develop and maintain a counseling relationship;				
2.3	establish individual goals and objectives of counseling;				
2.4	assist an individual with crisis resolution;				
2.5	facilitate an individual's independent decision-making;				
2.6	conduct group counseling sessions on adjustment and/or other vocational problems, when appropriate;				
2.7	involve, when appropriate, the individual's family/significant others in the counseling sessions;				
2.8	recommend strategies to resolve identified problems that impede the rehabilitation process.				

3.0 Program graduates shall satisfactorily practice rehabilitation counseling in rehabilitation planning and case management. Tasks typically include the ability to:

		EXCELLENT	GOOD	POOR	N/A
3.1	determine the adequacy of information for rehabilitation planning;				
3.2	integrate cultural, social, economic, disability-related, and environmental factors in planning;				
3.3	identify available resources and determine jointly, with the consumer, an appropriate rehabilitation plan;				
3.4	facilitate with the individual the development of a rehabilitation and/or independent living plan;				
3.5	communicate with other service providers involved with the individual and/or the family				
3.6	determine mutual responsibilities with other service providers involved with the individual/family;				
3.7	refer individuals to other community resources when appropriate; sessions;				
3.8	assist individuals in identifying potential fiscal resources to obtain needed services;				
3.9	serve as a consultant to other community agencies to promote the integration of individuals within the community;				

3.10	market the benefits and availability of rehabilitation services				
3.11	identify appropriate computer-related resources and assistive technology				

4.0 Program graduates shall satisfactorily practice rehabilitation counseling by using knowledge of vocational and career development. Tasks typically include the ability to:

		EXCELLENT	GOOD	POOR	N/A
4.1	understand consumer vocational goals and capabilities related to the world of work;				
4.2	utilize career/occupational materials and labor market information;				
4.3	explore occupational alternatives and develop career plans;				
4.4	understand career development theories and the importance of work to individuals;				
4.5	identify the prerequisite experiences and relevant training for career goals selected;				
4.6	determine and resolve job adjustment problems. and/or other vocational problems, when appropriate;				

5.0 Program graduates shall satisfactorily practice rehabilitation counseling through the identification and utilization of assessment information. Tasks typically include the ability to:

		EXCELLENT	GOOD	POOR	N/A
5.1	secure information about the existence, onset, severity, progression, and expected duration of an individual's disability;				
5.2	determine an individual's eligibility for rehabilitation services and/or programs;				
5.3	evaluate the feasibility of an individual's rehabilitation or independent living objectives;				
5.4	review assessment information to determine appropriate services;				
5.5	consult with professionals in other disciplines;				
5.6	assess the relevant vocational knowledge and experience of an individual;				
5.7	interpret assessment/evaluation results to the individual and/or family member;				
5.8	assess the individual's capabilities to make decisions;				
5.9	determine an individual's vocational or independent living skills, aptitudes, interests, and preferences;				
5.10	determine an individual's need for rehabilitation engineering/technology services.				

6.0 Program graduates shall satisfactorily practice rehabilitation counseling in job development, placement, and job retention. Tasks typically include the ability to:

		EXCELLENT	GOOD	POOR	N/A
6.1	obtain and use labor market information;				
6.2	identify and contact employers to develop job opportunities;				
6.3	evaluate work activities through the use of job and task analyses;				
6.4	modify and restructure jobs and use assistive devices, where appropriate;				
6.5	consult with experts to increase the functioning of individuals; selected;				
6.6	educate with experts to increase the functioning of individuals; when appropriate;				
6.7	assist employers to identify, modify, and/or eliminate architectural, procedural, and/or attitudinal barrier;				
6.8	review available data to determine potential person/job match;				
6.9	teach appropriate job-seeking and job retention skills;				
6.10	provide support services to facilitate job retention;				
6.11	establish follow-up and/or follow-along procedures to maximize an individual's independent functioning.				

7.0 Program graduates shall satisfactorily practice rehabilitation counseling by using information from rehabilitation research. Tasks typically include the ability to:

		EXCELLENT	GOOD	POOR	N/A
7.1	obtain and apply information from professional literature and research in rehabilitation counseling;				
7.2	participate in agency or community research activities, studies, and projects.				

PART II - General Skills/Attitudes

1.0 Work Performance

		EXCELLENT	GOOD	POOR	N/A
1.1	ability to organize information for records or reports				
1.2	clarity and accuracy or records or reports				
1.3	ability to carry out instructions or directions				

1.4 competence in completing assigned tasks				
1.5 competency in planning and organizing work				
1.6 flexibility in adapting to work situations				
1.7 initiative in presenting and developing new ideas				
1.8 ability to work under pressure				
1.9 skill in handling special assignments				

2.0 RESPONSE TO SUPERVISION

	EXCELLENT	GOOD	POOR	N/A
2.1 quality of relationship with supervisor				
2.2 ability to consult with supervisor for assistance				
2.3 ability to use supervisory help in performance of work				
2.4 interest demonstrated through observation				
2.5 ability to express feelings in supervisory conferences				
2.6 prompt and prepared for conferences with supervisor				
2.7 ability to accept criticism ideas				

3.0 Acceptance of professional role

	EXCELLENT	GOOD	POOR	N/A
3.1 ability to accept professional responsibility				
3.2 quality of relationship with agency/facility staff members				
3.3 relationship with other professionals in the community				
3.4 attitudes toward agency/facility policies and procedures				
3.5 potential professional contribution in the human services field				

ADDITIONAL REMARKS

Agency/Facility	Date
Signature of Supervisor	Title
Signature of Student	Date

CONFIDENTIAL!
STUDENT COUNSELOR EVALUATION OF SUPERVISOR*

SUGGESTED USE: The field work supervisor could obtain feedback on his/her supervision by asking student counselors to complete this form. The evaluation could be done at mid-term and/or final. The purposes are twofold: (1) to provide feedback for improving supervision, and (2) to encourage communication between the supervisor and the student counselor.

Name of Internship Supervisor________________________________

Period covered:_____________________ to ____________________

DIRECTIONS: The student counselor when asked to do so is to make an evaluation of the supervision received. Circle the number which best represents how you, the student counselor, feel about the supervision received. After the form is completed, the supervisor may suggest a meeting to discuss the supervision desired.

		Poor		Adequate		Good	
1)	Gives time and energy in observing, tape processing and/or case conferences	1	2	3	4	5	6
2)	Accepts and respects me as a person	1	2	3	4	5	6
3)	Recognizes and encourages further development of my strengths and capabilities	1	2	3	4	5	6
4)	Gives me useful feedback when I do something well	1	2	3	4	5	6
5)	Provides me the freedom to develop flexible and effective counseling styles	1	2	3	4	5	6
6)	Encourages and listens to my ideas and suggestions for developing my counseling and/or assessment skills	1	2	3	4	5	6
7)	Provides suggestions for developing my counseling and/or assessment skills	1	2	3	4	5	6
8)	Helps me to understand the implications and dynamics of the counseling and/or assessment approaches I use	1	2	3	4	5	6

*Adapted from an evaluation form by Dr. Harold Hackney, Assistant Professor, Purdue University.

9)	Encourages me to use new and different techniques when appropriate	1	2	3	4	5	6
10)	Is spontaneous and flexible in the supervisory sessions	1	2	3	4	5	6
11)	Helps me to define and achieve specific concrete goals for myself during the field work experience	1	2	3	4	5	6
12)	Gives me useful feedback when I do something wrong	1	2	3	4	5	6
13)	Allows me to discuss problems I encounter in my field work setting	1	2	3	4	5	6
14)	Pays amount of attention to both me and my clients	1	2	3	4	5	6
15)	Focuses on both verbal and nonverbal behavior in me and in my clients	1	2	3	4	5	6
16)	Helps me define and maintain ethical behavior in counseling, case management, and assessment	1	2	3	4	5	6
17)	Encourages me to engage in professional behavior	1	2	3	4	5	6
18)	Maintains confidentiality in material discussed in supervisory sessions	1	2	3	4	5	6
19)	Deals with both content and affect when supervising	1	2	3	4	5	6
20)	Focuses on the implications, consequences and contingencies of specific behaviors in counseling, assessment and supervision	1	2	3	4	5	6
21)	Helps me organize relevant case data in planning goals and strategies with my client	1	2	3	4	5	6

22) Helps me to formulate a theoretically sound rationale of human behavior	1	2	3	4	5	6
23) Offers resource information when I request or need it	1	2	3	4	5	6
24) Allows and encourages me to evaluate myself	1	2	3	4	5	6
25) Explains his/her criteria for evaluation clearly and in behavioral terms	1	2	3	4	5	6
26) Applies his/her criteria fairly in evaluating my counseling performance	1	2	3	4	5	6

Additional Comments and/or Suggestions

Date

Field Work Student

My signature indicates that I have read the above report and have discussed the content with my supervisor. It does not necessarily indicate that I agree with the report in part or in whole.

Date

Signature of Supervisor

Student Opinion of Teaching Survey

Your instructor has requested your evaluation of his/her teaching effectiveness. Please circle the number that best represents your opinion about the following statements. Be as honest as you can, for your opinions will assist in the development and direction of future courses.

Course: Seminar in Psychiatric Rehabilitation
Instructor: Michelle Geckle, M.Ed., CRC
Date: September 1995 - February 1996

1. Degree to which the course content and topical areas included were comprehensive and representative. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

2. Degree to which the information learned in the course was relevant and useful in your clinical work. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

3. Degree to which your expectations regarding the amount of skill development were met by the course. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

4. Degree to which the instructor helped to transfer training principles and theory to the actual work or clinical setting. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

5. Ability of the instructor to assist students in formulating their own solutions to problems or questions. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

Degree to which the following instructional methods employed were useful:

6. Lecture N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

7. Handouts/Resource Materials N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

8. Supplemental Readings N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

9. Experimental Activities N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

10. Videotapes N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

11. Question and Answer Period N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

12. Extent to which the instructional materials (handouts, resources) were well-organized and comprehensive. N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

13. Degree of openness, spontaneity, humor and energy exhibited by the instructor. N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

14. Degree to which the instructor encouraged cohesiveness, trust and responsiveness in the students. N/A

Low					Average				High
1	2	3	4	5	6	7	8	9	10

15. Extent to which the instructor fielded responses and questions from students with sensitivity and respect. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

16. Degree to which you felt able to openly and freely express your opinions to your instructor. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

17. Degree to which the methods employed to evaluate your performance and effectiveness in the course were fair. N/A

Low Average High
1 2 3 4 5 6 7 8 9 10

18. Compared to other instructors you have had, this instructor's teaching effectiveness is:

Low Average High
1 2 3 4 5 6 7 8 9 10

What did your instructor do particularly well in this course?____________________

What did your instructor do rather poorly in this course?____________________

What did you find to be the most valuable experience(s) during the course?____________________

What did you find to be the least valuable experience(s) during the course?____________________

Please make any comments or suggestions for change or improvement in this course which you would like.____________________

RECORD KEEPING

APPROVED BY THE MEDICAL RECORD COMMITTEE ON 01/13/94

UPMC APPROVED ABBREVIATIONS LIST

a	A wave
$\bar{a}$	before
AA	aplastic anemia
aa	of each
AAA	abdominal aortic aneurysm
AAO	awake, alert & oriented
AAROM	**active assistive range of motion**
abd	abduction
abd.	abdomen
ABG	arterial blood gases
Abn	abnormal
Abor	abortion
ABP	arterial blood pressure
abst.	abstract
A/C	assist/control ventilation
ac	before meals
a.c.	anterior chamber
acc., accom.	accommodation
Accu✓	accucheck
ACD	anticoagulant citrated dextrose
AC IOL	anterior chamber intra-ocular lens
AC joint	acromioclavicular joint
ACL	anterior cruciate ligament
ACT	activated clotting time
ACTH	adrenocorticotrophic hormone
AD	right ear
ad lib	as desired
ADA	American Diabetes Association
Adapt. Equip.	**Adaptive Equipment**
ADD	addition
add.	adduction
ADD. Therapy	additional therapy
ADHD	attention deficit hyperactivity disorder
ADL	activities of daily living
adm.	admission, admitted
AFB	acid-fast bacillus
AFBY	aorta bifemoral bypass
AFib	atrial fibrillation
A-flut	atrial flutter
AFM	aerosol face mask
AFM x 2	double aerosol face mask
A.F.O.	ankle foot orthosis
A-G ratio	albumin - globulin ration
AGH	Allegheny General Hospital
AgNo$_3$	silver nitrate

AIDS	Acquired Immunodeficiency Syndrome
AIHA	autoimmune hemolytic anemia
Air Con	Air Contrast
AJ	ankle jerk
AK	above the knee
AKA	above knee amputation
A.L.	arterial line
ALB	albumin
ALL	Acute lymphocytic leukemia
ALN	anterior lower neck
allo	allogeneic
ALP	**Alkaline Phosphatase**
ALS	amyotrophic lateral sclerosis
ALT	**Alanine Aminotransferase**
ALTP	Argon laser trabeculoplasty
AM	before noon
A-M prothesis	Austin Moore Prosthesis
AMA	against medical advice
amb.	ambulatory
ambu	ambulate
AMI	acute myocardial infarction
AML	acute myeloblastic leukemia
AMML	acute monomyeloblastic leukemia
amp.	ampule
amt.	amount
AMYL	amylase
ANA	antinuclear antibodies
ANB	naphtyl butyrate
Anes	anesthesia
angio	angiogram
ANLL	acute non-lymphocytic leukemia
ant	anterior
AODM	adult onset diabetes mellitus
AP	anterior to posterior
A & P	auscultation and percussion
AP & Lat	anterior-posterior, lateral (x-ray)
APC	atrial premature contractions
APTT	activated partial thromboplastin time
ARA-A	vidarabine (Vira - A)
ARA-C	cytarabine (Cytosar)
ARC	AIDS related complex
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
ARMD	age related macular degeneration
AROM	active range of motion
ART	arterial
Arthro	arthrogram
AS	left ear
A.S.	aortic stenosis
AS-D CA	naphtyl choloracetate

ASA	acetylsalicylic acid
ASA, I, II, III, IV, V, VI, E	American Society of Anesthesiologists class I, II, III, IV, V, VI, E
ASAP	as soon as possible
ASB	anesthesia standby
ASCVD	arteriosclerotic cardiovascular disease
ASHD	arteriosclerotic heart disease
Asmt	assessment
ASO	arteriosclerosis obliterans
asp.	aspirate
ASPVD	arteriosclerotic peripheral vascular disease
Ⓐ	Assist
AST	asparate aminotransferase
ASTRO	astrocytoma
ASVD	arteriosclerotic vascular disease
AT	applanation tonometry
ATA	atmosphere absolute
ATG	Antithymocyte globulin
Atmos	atmospheric
ATN	acute-tubular necrosis
A.U.	both ears
Au	gold
auto	autologous
AV	arterial ventricular
AVM	arterial venous malformation
AVR	aortic valve replacement
A & W	alive and well
AWMI	anterior wall myocardial infarction
ax.	axillary
AX FEM By	axilo femoral bypass
AXIL or AX	axilla

==

B

B	Black
Ⓑ	Both
Ba E or BE	barium enema
BaS	barium swallow
basos	basophils
BAT	brightness acuity test
BBB	Bundle Branch Block
B.B.B.	Blood-Brain Barrier
BBR	bibasilar rales
BBS	bilateral breath sounds
B cell	bone marrow derived lymphocytes

B/C/L	bun, creatinine, lytes
BC/BS	Blue Cross/Blue Shield
BCNU	carmustine
BE/LGI	barium enema
BGDR	background diabetic retinopathy
bid	twice daily
bicarb	bicarbonate
bilat or b	bilateral
BiVAD	**Bi-Ventricular Assist Device**
BJ	biceps jerk
BK	below knee
BKA	below knee amputation
bld	blood
blk	block
BM	bowel movement
B.M.	bone marrow
BMR	basal, metabolic rate
BMT	bone marrow transplant
BOS	**Base of Support**
BP	blood pressure
BPH	benign prostatic hypertrophy
BPPN	**Benign paroxysmal postional nystagmus**
BPPV	**Benign paroxysmal postional vertigo**
BR	bedrest
BRJ	brachioradialis jerk
BRM	biological response modifier
BRP	bathroom privileges
BS	blood sugar
B.S.	bowel sounds
BSC	bedside commode
BSER	brainstem evoked response
BSO	bilateral salpingo-oophorectomy
BSP	bromsulphalein test
BSu	blood sugar
BSS	balanced salt solution
BSS Plus	balanced salt solution Plus
BSW	bedscale weight
BTFS	breast tumor frozen section
BUN	blood-urea-nitrogen
BVR	Bureau of Vocational Rehab.
Bx	biopsy

C

C_1 C_2	1st cervical vertebrae/2nd cervical vertebrae
C + DB	cough & deep breathe
C	complement
C.	centigrade

C. Diff	C. difficile toxin
$\bar{c}$	with
CA	carcinoma
Ca+	calcium
CABG	coronary artery bypass graft
CAD	coronary artery disease
CAH	chronic active hepatitis
cal	calorie
cap.	capsule
CAPD	chronic ambulatory peritoneal dialysis
Carot	carotid
CAT	cataract
CAT Scan/CT	computerized axial tomograph
CAVH-D	**Continuous Arterial to Venous Hemofiltration w/Dialysis**
CAX	central axis
c/d	cup-disc ratio
CAVH	continuous arterial venous hemofiltration
CBC	complete blood count
CBD	common bile duct
CBR	complete bed rest
CC	chief complaint
cc	cubic centimeter
cc/HR	cubic centimeter per hour
CCNU	lomustine (Cee-Nu)
CCU	Coronary Care Unit
C.D.	closed drainage
cent.	central
cerv	cervical
CF	finger counting
CH_{50}	total hemolytic complement
CHB	complete heart block
Chemo/BRM	chemotherapy biological response
Chest PT	chest physical therapy
CHF	congestive heart failure
CHOP	(chemotherapy medications) Cytoxin, Adriamycin, Oncovin, Prednisone
CHP	Children's Hospital of Pittsburgh
CISI	Central Imaging Services, Inc.
C.L.A. (ASCP)	Clinical Laboratory Assistant
Cl	chloride
CLL	chronic lymphocytic leukemia
C.L.S. (NCA)	Clinical Laboratory Scientist
C.L.T. (NCA)	Clinical Laboratory Technician
C.L.T. (HEW)	Clinical Laboratory Technician
CM	commercial insurance
cm.	centimeter
CMC	carpal metacarpal
CML	chronic myelocytic leukemia
CMV	cytomegalovirus
C.M.V.	controlled mechanical ventilation

CNRN	Certified Neuroscience Registered Nurse
CNS	central nervous system
C.N.S.	Clinical Nurse Specialist
Co-57 or ^{57} Co	Cobalt - 57
Co-60 or ^{60} Co	Cobalt - 60
C/O	complains of
CO	carbon monoxide
C.O.	cardiac output
CO_2	carbon dioxide
coag	coagulation studies
COLD	chronic obstructive lung disease
conj.	conjunctiva
COP	Cytoxan, Oncovin, Prednisone
cop	colloid oncotic pressure
COPD	chronic obstructive pulmonary disease
COTA/L	Certified Occupational Therapy Assistant/Licensed
CP	chest pain
CPAP	continuous positive airway pressure
CPFT	Certified Pulmonary Function Technician
CPK	creatinine phosphokinase
CPMM	continuous passive motion machine
CPR	cardiopulmonary resuscitation
CP's	contact lenses
C.P.T.	chest physical therapy
CPX	complex
Cr-5l or 51 Cr	Chromium - 51
CRA	central retinal artery
creat	creatinine
CRF	chronic renal failure
CRNA	Certified Registered Nurse Anesthetist
CRNP	Certified Registered Nurse Practitioner
CRRT	Continuous Renal Replacement Therapy
CRST	cutaneous systemic sclerosis syndrome
crt.	hematocrit
CRTT	Certified Respiratory Therapy Technician
CRV	central retinal vein
CRVT	central retinal vein thrombosis
C & S	culture & sensitivity
CS	contact spot
C.S.	central supply
CSA	cyclosporine level
CSF	cerebrospinal fluid
C.S.F.	colony stimulating factor
CSG	chronic simple glaucoma
C-spine	cervical spine
CT	completed tomography
C.T.	chest tube
ct.	count
CTB	cease to breathe
CVA	cerebrovascular accident

CVI	central venous insertion
CVMH	Conemaugh Valley Memorial Hospital
CVP	central venous pressure
CVVH	continuous venous-to-venous hemofiltration
CVVH-D	**Continuous venous to venous hemofiltration w/Dialysis**
CX or CERV	cervical
cx	culture
cx.	circumflex
CXR	chest x-ray
CYCLO	cyclopropane
CYA	Cyclosporine (Cyclosporin-A)

==

D

D_1D_2, etc.	1st dorsal vertebrae/2nd dorsal vertebrae
D_5	dextrose 5%
$D_{5\frac{1}{4}}$NS	dextrose 5% in ¼% saline
$D_{5\frac{1}{4}}$NS	dextrose 5% in ½% saline
D_5NSS	dextrose 5% in normal saline solution
D_5R	dextrose 5% in Ringers
D_5LR	dextrose 5% in lactated Ringer's
D	deltoid
D & I	dry and intact
DAD	diffuse alveolar damage
DAFM	double aerosol face mask
DB	deep breathing
Dbl	double
D & C	dilatation and curettage
D/C	discontinue
D.C.	direct current
decub	decubitus
def.	deficits
Dept.	department
DES	diethylstilbestrol
dex.	dextrose
DF	dorsiflexion
DFA	dorsiflexion assist
D.F.A.	D. fluorescent antibody
DI	diabetes insipidus
DIC	disseminated intravascular coagulation
Diff	differential
Dig	digitalis
dil	dilute
D.I.P.	distal interphalangeal
DIST	distal
div. or ÷	divide
DJD	degenerative joint disease
DL	danger list

dl	deciliter
DL & B	direct laryngoscopy and bronchoscopy
DM	diabetes mellitus
Dmax	dose at the point of electronic equilibrium (i.e. depending upon context usage)
D/NSS	dextrose in normal saline solution
DNR	Do Not Resuscitate
DOA	dead on arrival
DOB	date of birth
DOE	dyspnea on exertion
dop	doppler
DOS	dosimetry
doz.	dozen
DPA	Dept. of Public Assistance
dr. or ʒ	dram
Dr.	doctor
D.R.	diabetic retinopathy
DRG	Diagnosis-Related Group
Drng.	drainage
drsg.	dressing
DO	Doctor of osteopathy/resident
D/S	dextrose & saline
DSD	dry, sterile dressing
dsch	discharge
DSR	double side rail
DST	daylight saving time
DTIC	dacarbazine
DTR	deep tendon reflexes
D.T.R.	dietetic technician registered
duo	duotube
Dup	duplicate
DVT	deep venous thrombosis
Dx	diagnosis

E

ea.	each
EBL	estimated blood loss
E.C.	enteric coated
ECCE	extra capsular cataract extraction
E.C.F.	Extended Care Facility
ECG/EKG	electrocardiogram
E.Coli	escherichia coli
ECMO	extra-corporeal membrane oxygenator
ECOG	Eastern Cooperative Oncology Group
ect.	Ectopic

ED	Emergency Department
EDV	end diastolic volume
EEG	electroencephalogram
EEIP	Eye & Ear Institute Pavilion
EENT	eyes, ears, nose and throat
eg.	for example
EHL	electrohydrocalculi lithotripsy of the bladder
E.H.L.	extensor halluces longus
EKC	epidemic keratoconjunctivitis
elix.	elixir
EMG	electromyogram
EMMV	extended mandatory minute volume
ENA	extractable nuclear antigens
ENDO	endotracheal
endo	endoscopy
ENG	electronystagmograph
Enh	enhanced
E.N.T.	ear-nose-throat
EOG	electro-oculo gram
EOM	extraocular muscles
EOR/ER	Emergency Room
eos	eosinophils
EPC	**extra corporeal-chemophotopheresis**
EPI	epinephrine
EPS	electrophysiological studies
(ER)	**External Rotation**
ERA	evoked response audiometry
ERCP	endoscopic retrograde choleangio pancreatography
ERG	electro retino gram
ERRL	equal, round, reactive to light
ESOPH	esophageal
ESR	estimated sedimentation rate
ESRD	end stage renal disease
est.	estimated
E.S.T.	Eastern Standard Time
ESV	end systolic volume
ESWL	extracorporeal shock wave lithotripsy
et (al)	and (other; etiology)
ET	endotracheal tube
E.T.	esotropia
etc.	etcetera
ETOH	ethyl alcohol
ETT	endotracheal tube
EVD	external ventricular drain
exam.	examination
ext	extremities
(EXT) or /	Extension

F

5-FC	flucytosine
5-FU	fluorouracil
F	female
F.	fahrenheit
FABR	fabrication
FAL	femoral arterial line
FAT	fluorescent antibody test
F/B	followed by
FB	foreign body
FBS	fasting blood sugar
FCR	flexor carpi radialis tenodesis
fdgs	feedings
FDP	fibrin degradation products
Fe	iron
fem.	femoral
FEM-POP bypass	femoral-popliteal bypass
FEM-TIB-By	femoral tibial bypass
$FeSO_4$	Ferrous sulfate
FEV_1	forced expiratory volume in 1 second
FEV_3	forced expiratory volume in 3 seconds
F_iO_2	fractional inspired oxygen concentration
FFP	fresh frozen plasma
FH	family history
fib	fibrillation
fkn	function
Fl. ext	fluid extract
FLD	field
flex	flexion
F → N	finger to nose
FLUO	Fluothane
fluoro	fluoroscopy
FM	face mask
FMG	fine mesh gauze
FSH	follicle stimulating hormone
FSW (fsw)	feet of sea water (pressure)
ft.	foot
FTA	fluorescent treponemal antibody
f/u	follow up
FUDR	floxuridine
FUO	fever of unknown origin
FVC	forced vital capacity
F.W.B.	full weight bearing
Fx	fracture

G

g or gm	gram
G.H.	gleno humeral
G.I.	gastrointestinal
Ga-67 or ^{67} Ga	Gallium - 67
gal.	gallon
GB	gallbladder
GB Series	gallbladder series
G.B.M. or Glio	glioblastoma multiforme
gen.	general
Gen. Anest.	general anesthesia
GENT	gentamicin
GFR	glomerular filtration rate
GGTP	gamma glutamyl transpeptidase
GI	gastrointestinal
gl.	glaucoma
glu	glucose
GM-CSF	granulocyte-macrophage colony stimulating factor
GN	Graduate Nurse
gn	glomerulonephritis
GPN	Graduate Practical Nurse
G.P.R.C.	Greater Pittsburgh Rehab Center
gr	grain
grav	gravida
Gs	glut sets
GSW	gunshot wound
G-tube	gastrostomy tube
GTR	**Gait Training**
GTT	glucose tolerance test
gtt	drop
gtts	drops
GU	genito-urinary
GVHD	graft versus Host disease
Gyn	gynecology

===

H

H - S	heel to shin
H or Hypo	hypodermic
h or hr.	hour
H Mgmt	**Home Management**
H & H	hemoglobin and hematocrit
H & L	heart & lung
H & N	head and neck
H & P	History & Physical
H_2O	water

H/A	headache
h/o	history of
H.B.	heartblock
H-BIG	hepatitis-B immune globulin (human)
HB, hb, Hgb	hemoglobin
HBO	hyperbaric oxygen (high pressure O)
HBP	high blood pressure
HC	Home Care
HCG	human chorionic gonadotropin
HCT	hematocrit
HCV	hepatitis C virus
HDR	heparin dose response
HEENT	head, eyes, ears, nose, throat
heme	hemetest
hep	heparin
hep flush	heparin flush
hep lock or HL	heparin lock
H-Flu	hemophilus influenzae
Hg.	mercury
HG	handgrasp
Hgb	hemoglobin
HGES	handgrasp equal & strong
HGH	human growth hormone
HIV	human immunodeficiency virus
hlth. teach	health teaching
HM	head movement
HN	Head Nurse
HNP	Herniated nucleus pulposus
HO	House Officer
HOB	head of bed
HOH	hard of hearing
HPI	history of present illness
HPNS	high pressure nervous syndrome
HPT	heparin protamine titration
HR	heart rate
hr.	hour
HRC	Harmarville Rehab Center
HS	Hamstring sets
hs	hour of sleep
Ht	height in centimeters
ht	height
HTN	hypertension
Hx	history

I

Ⓘ	independent
I & O	intake & output
I-123	Iodine - 123
I-125	Iodine - 125
I-131	Iodine - 131
IABP	intra-aortic balloon pump
ICCE	intracapsular cataract extraction
I.C.D.B.	incomplete data base
ICP	intracranial pressure
ICS	intercostal space
ICU	Intensive Care Unit
ID	identification
I.D.	Infectious Disease
I & D	incision and drainage
IDDM	insulin dependent diabetes mellitus
IEP	immunoelectrophoresis
IF	inspiratory force
IHSS	idiopathic hypertrophic subaortic stenosis
IJ	internal jugular
IM	intramuscular
IMF	intermaxillary fixation
imp	impression
IMV	intermittent mandatory ventilation
In-111	Indium - 111
in.	inch
incont.	incontinent
inf.	inferior
INH	isoniazid
Inh. T. or I.T.	inhalation therapy
INQ	inferior nasal quadrant
insuff.	insufficiency
Int	internal
Int. Cerv. Trx.	intermittent cervical traction
int. rot.	internal rotation
integ	integumentary
inter	intermediate
intracap.	intracapsular
IOFB	intraocular foreign body
IOL	intraocular lens
IOP	intraocular pressure
IPG	impedance plethysmography or plethysmography
IPN	interstitial pneumonia
IPPB	intermittent positive pressure breathing
IPPV	intermittent positive pressure ventilation
IPT	intermittent pelvic traction
irrig	irrigate
IS	incentive spirometer

ISO	isodose
Isos	isoenzymes
ITP	idiopathic thrombocytopenic purpura
ITQ	inferior temporal quadrant
IU	international unit
IV	intravenously
I.V. team or IVT	intravenous therapy team
I.V.C.	intravenous cholangiogram
IVC	inferior vena cava
IVF	IV fluids
IVP	intravenous pyelogram
IVp	intravenous pyelogram
IVS/PVW	int ventricular system/post ventricular wall
I.V.S.S.	I.V. soluset
IWMI	inferior wall myocardial infarction

J

J	Jaeger
JP	Jackson - Pratt
J-tube	jejunostomy tube
JHHA	Jewish Home/Hospital for the Aged
JODM	juvenile onset diabetes mellitus
JR	junctional rhythm
JRA	juvenile rheumatoid arthritis
JVD	jugular venous distention

K

K	thousand
Ⓚ	Kosher
K+	potassium
Kcal	kilocalories
KCL	potassium chloride
kg	kilogram
KID	kidney
KJ	knee jerk
KS	ketosteriods
KUB	kidney-ureter-bladder
KVO	keep vein open

L

L/min	liters per minute
L_1, L_2	1st lumbar vertebrae, etc.
(L)	left
L or l	liter
L - R	left to right
L & A	light and accommodation
LA	left atrium
lab	laboratory
LAO	left anterior oblique
lap	laparotomy
LAT	lateral
lb.	pound
LBBB	left bundle branch block
LBP	low back pain
LCS	low continuous suction
LDH	lactic acid dehydrogenase
LE	lower extremity
L.E.	lupus erythematosus
LFT	liver function test
LH	luteinizing hormone
lig	ligament
liq.	liquid
LIS	low intermittent suction
LIT	liver injury test
Lg	large
LL	lower lid
LLE	left lower extremity
LLL	left lower lobe
L.L.L.	left lower lid
LLQ	left lower quadrant
LMD	Local Medical Doctor
LMP	last menstrual period
Loc. Anest.	local anesthesia
L.O.C.	loss of consciousness
LOS	length of stay
LP	lumbar puncture
L.P.	light perception
LPN	Licensed Practical Nurse
LPO	left posterior oblique
LPT	Licensed Physical Therapist
LR	lactated ringers
LS	lumbosacral
LS-Spine	lumbar sacral spine
LTA	laryngotracheal applicator
LTM	long-term memory
LTP	laser trabeculoplasty
LTR	lower trunk rotation

LUE	left upper extremity
LUL	left upper lobe
L.U.L.	left upper lid
LUQ	left upper quadrant
LV	left ventricular
LVAD	**Left Ventricular Assist Device**
LVAS	**Left Ventricular Assist System**
LVH	left ventricular hypertrophy
Lytes	electrolytes

==

M

Ⓜ	murmur
m	meter
m/r/g	murmur/rub/gallop
MA	Medical Assistance
ma	milliampere
Macroggts	20 drops/cc or 10 drops/cc
MAE	moves all extremities
Mammo	mammogram
MAP	mean arterial pressure
MAR	medication administration record
MAST	medical anti-shock trouser
MAT	multifocal atrial tachycardia
max.	maximum
MAXⒶ	**Maximum Assist**
MBBS	Bachelor of Medicine, Bachelor of Surgery (Same as MD)
MC	Medicare
mc.	millicurie
mcg	microgram
mcgtts	60 drops/cc
mCi	millcurie
MCTD	mixed connective tissue disease
MD	Medical Doctor
MDI	metered dose inhaler
med.	medical
Med. Rec.	Medical Records
meds.	medications
mEq.	milliequivalent
mEq./L	milliequivalent/liter
mets	metastases
mg	milligram
mg/dl	milligrams per deciliter
mg/min	milligrams per minute
mg/ml	milligrams per milliliter
$MgSO_4$	magnesium sulfate
MGT	management

MI	myocardial infarction
MICU	medical intensive care unit
min	minute
MINⒶ	**Minimum Assist**
min.	minimum
misc.	miscellaneous
mixt.	mixture
ml	milliliter
ML/MIN	milliters per minute
MLT (ASCP)	Medical Laboratory Technician
MM	multiple myeloma
mm	millimeter
MMOA	maxillary mandibular odontectomy alveolectomy
MMPI	Minnesota multiphasic personality inventory
MMT	**Manual Muscle Testing**
mo.	month
mod	moderate
MODⒶ	**Moderate Assist**
MOM	milk of magnesia
monos	monocytes
MOPP	nitrogen mustard, Oncouvin, procarbaxine, prednisone
movt.	movement
MP (MCP)	metacarpophalangeal
M.P.D.	moisture permeable dressing
M.P.G.N.	membrane proliferative glomerulonephritis
MR	mitral regurgitation (insufficiency)
MRI	magnetic resonance imaging
MRx1	may repeat times 1
MS	mental status
M.S.	multiple sclerosis
MSO_4	morphine sulfate
MSS	minor surgery suite
MSW	Master in Social Worker
msw	meters of sea water (pressure)
MSW, ACSW	Master in Social Work, Academy of Certified Social Workers
MSW, Intern	Master in Social Work, graduate student
MT or MTP	metatarsophalangeal
M.T.	Medical Technologist
M.T. (ASCP) SBB	Specialist, Blood Bank
MTX	Methotrexate
MUD	matched unrelated donor
MUGA	multiple gated acquisition
MUH	Montefiore University Hospital
Mus. skel	musculoskeletal
MVA	motor vehicle accident
MVI	multiple vitamin
MVR	mitral valve replacement
myel	myelocyte
Myelo	myelogram

N

N & T	nose and throat
N & V	nausea and vomiting
N	noon
N/A	not applicable
NA	Nursing Assistant
Na+	sodium
NaCL	sodium chloride, salt
NAD	no acute distress
NaF	sodium fluoride
$NaHCO_3$	sodium bicarbonate
N/C	nasal cannula
NCCU	neurosurgical continuous care unit
NCV	nerve conduction velocity
NDDM	non-insulin dependent diabetes mellitus
NDT	**Neuro Developmental Treatment**
neg	negative
NENT	nasal endotracheal tube
Neuro	neurological
ng	nanograms
NG	nasogastric
NGT	nasogastric tube
NHL	Non-Hodgkins Lymphoma
N.H. Pass.	North Hills Passavant Hospital
NICU	Neurosurgical Intensive Care Unit
NIDDM	non insulin dependent diabetes mellitus
NKA	no known allergies
NKDA	no known drug allergies
NKHC	nonketotic hyperosmotic coma
NKHS	nonketotic hyperosmotic state
NLA	neuroleptic anesthesia
NLP	no light perception
NM	neuromuscular
nm	nanometers
NMR	nuclear magnetic resonance
N/N	negative/negative
no.	number
noc. or noct.	night
NOS	not otherwise specified
NP	nasopharynx
N.P.	neutrogenic precautions
NPH	NPH type insulin
NPN	non protein nitrogen
NPO	nothing by mouth
N.R.	non-reactive; no response
nrsg.	nursing
NS	normal saline
NSAID	non-steroid anti-inflammatory drugs

NSR	normal sinus rhythm
NSS	normal saline solution
NSQ	not sufficient quantity
NSU	Neurosurgical unit
NT	nasotracheal
NTG	nitroglycerin
NVD	nausea, vomiting and diarrhea
NVS	neurovascular status
NWB	non-weight bearing

O

17 OHCS	17 - hydroxycorticosteroid
O x 3	Oriented times three
O & P	ova and parasites
o	no
OA	osteoarthritis
OB	obstetrics
obj.	objective
OBL	oblique
OBS	organic brain syndrome
Occ	occasional
OCG	oral cholecystogram
OD	overdose
O.D.	right eye
OENT	oral endotracheal tube
O.G.	oral gastric tube
OHTx	orthotopic heart transplant
oint	ointment
OJ	orange juice
OLTx	orthotopic liver transplant
ON	optic nerve
OOB	out of bed
OP	outpatient
op	operation
OPD	Outpatient Department
OPG	ocular plethysmography
Ophth.	ophthalmology
OR	operating room
ORIF	open reduction internal fixation
ORN	osteoradionecrosis
ORT	operating room technician
Orth. or Ortho.	orthopedic
O.S.	left eye
os	mouth
O_2	oxygen
OT	occupational therapy

OTA	open to air
OTAS	Occupational Therapy Assistant Student
OTO	otology
OTR/L	Occupational Therapist Registered/Licensed
OTS	Occupational Therapy Student
O.U.	both eyes
ox	oximetry
oz or ℥.	ounce (fluid)

P

P-32 or ^{32}P	Phosphorus - 32
P & A	percussion and auscultation
P & T	peak and trough
P	pulse
$\overline{p}$	after
$\overline{p}$ prep	after prep
P.A.	Physician's Assistant
P. bars	parallel bars
P. Caps	posterior capsule
PA	pulmonary artery
PAC	premature atrial contraction
P_aCO_2	arterial carbon dioxide pressure
PACU	Post-Anesthesia Care Unit
PAD	**Pulmonary Arterial Diastolic**
palp	palpable
PAM	**Pulmonary Arterial Mean Pressure**
PAO_2	partial pressure of oxygen in the arterial blood
P_aO_2	arterial oxygen pressure
PA S/D	pulmonary artery systolic/diastolic
PAP	pulmonary artery pressure
Pap-smear	papanicolaou smear
PAR	postanesthetic recovery
PAS	periodic acid schiff
PAT	paroxysmal atrial tachycardia
Path	Pathology
PBI	protein-bound iodine
PC	posterior chamber
pc	after meals
PC IOL	posterior chamber intraocular lens
PCA	patient controlled analgesia
PCI	Pittsburgh Cancer Institute
PCL	posterior cruciate ligament
PCM	patient care manager
PCN	penicillin
PCO_2	carbon dioxide pressure
PCWP	pulmonary capillary wedge pressure

P.D.	postural drainage
PE	plantar ext.
P.E.	physical examination
PEG	percutaneous endoscopy gastrostomy
PEEP	positive and expiratory pressure
per	via
per os	by mouth
Perc.	percutaneous
periph	peripheral
PERRL	pupils equal, round reactive to light
PERRLA	pupils equal, round reactive to light and accommodation
PF	plantar flexion
PFT	pulmonary function test
PGYI	Post Graduate Year I
PGYII	Post Graduate Year II
PGYIII	Post Graduate Year III
PGYIV	Post Graduate Year IV
pH	hydrogen ion
Pharm D	Doctor of Pharmacy
Pharm.	pharmacy
PhD	Doctor of Philosophy
PI	peripheral iridectomy
P.I.	principal investigator
PICU	PAR/intensive care unit
PID	pelvic inflammatory disease
PIP	peak inspiratory pressure
PKP	penetrating keratoplasty
plts	platelets
PM	afternoon
PMD	Private Medical Doctor
PMH	past medical history
PMI	point of maximal impulse
PMM's	polymorphonuclear
PMN	polymorphonuclear
PMS	Pitt Medical Student
PMSI	Pitt Medical Student - First Year
PMSII	Pitt Medical Student - Second Year
PMSIII	Pitt Medical Student - Third Year
PMSIV	Pitt Medical Student - Fourth Year
PN_2	partial pressure of nitrogen
PND	paroxysmal nocturnal dyspnea
PNF	Proprioceptive Neuromuscular Facilitation
po	by mouth
PO_2	oxygen tension or pressure
POD	post-operative day
Port	portable
post	posterior
post-op	post operative
p.p.	post prandial
pp	pinprick

PPD	purified protein derivative (tuberculin test)
ppd	packs per day
P.P.(G)	postprandial (glucose)
PPES	pedal pushes equal and strong
P.R.	per rectum
PRBC	packed red blood cells
PRE	progressive resistive exercises
prec.	precautions
pre-op	pre-operative
preg.	pregnant
prep.	preparation
Presby or PUH	Presbyterian University Hospital
prev.	previous
PRL	prolactin
prn	whenever necessary
prob	problems
proc.	procedure
prod.	productive (cough)
prog.	prognosis
P.R.O.M.	passive range of motion
PROMM	passive range of motion machine
protime	prothrombin time
prox	proximal
P/S	pulmonary/systemic
PS	pulmonic stenosis
P.S.	physical status
P.S.B.O.	partial small bowel obstruction
PCS Cat	posterior subcapsular cataract
PSHx	past surgical history
psi	pounds per square inch
PSIG	pounds per square inch, gauge
PSP	phenolsulphthalein
PSS	progress systemic sclerosis (Scleroderma)
PSV	pressure support ventilation
psycho. soc.	psycho-social
P.T.	physical therapy
Pt.	patient
PTA	prior to admission
P.T.A.	Physical Therapist Assistant
PTB	patellar tendon bearing
PTCA	percutaneous transluminal coronary angioplasty
PTH	parathyroid hormone
PTM	patient monitored
PTT	partial thromboplastin time
PTU	propylthiouracil
PUD	peptic ulcer disease
Pulm	pulmonary
PVCs	premature ventricular contractions
PVD	peripheral vascular disease
PWB	partial weight bearing

Q

q	each
q.	every
q. __ hrs	every __ hours
QA	Quality Assurance
QC	Quik cath
qd	every day
qh	every hour
q hs	every night at bedtime
QI	Quality Improvement
qid	four times a day
qm	every morning
qn	every night
QNS	quantity not sufficient
qod	every other day
qoh	every four hours
qs	quantity sufficient
QS	quad sets
qt.	quart
Quad	Quadrant

R

(R)	right
R & M	routine and microscopic
(R) / (L) Lat	right and left lateral
R.EEG T.	registered electroencephalographic technologist
RA	right atrium
R.A.	rheumatoid arthritis
rad.	radial
Rad. Ther.	Radiation Therapy
RAEB	refractory anemia in excess blasts
RAIU	radioactive iodine uptake
RAL	radial arterial line
RAO	right anterior oblique
RBBB	right bundle branch block
RBC	red blood cells or count
RBCV	red blood cell volume
RCJS	Riverview Center for Jewish Seniors
RCR	rotator cuff repaire
RD	retinal detachment
RDP	random donor platelets
re:	reason
reg.	regular

rehab	rehabilitation
resp.	respiration
ret. detach.	retinal detachment
Retro	retrograde
RF	rheumatoid factor
Rh. neg.	rhesus factor negative
RHD	rheumatic heart failure
RIH	right inguinal hernia
RL	ringers lactate
RLE	right lower extremity
RLL	right lower lobe
R.L.L.	right lower lid
RLQ	right lower quadrant
RML	right middle lobe
RN	Registered Nurse
R/O	rule out
ROM	range of motion
ROS	review of systems
R.P.G.N.	rapidly progressive glomerulonephritis
R.Ph.	Registered Pharmacist
RPO	right posterior oblique
RPR	rapid plasm reagin
RR	recovery room
RRT	registered respiratory therapist
R.S.L.R.	reverse straight leg raise
rt	right
RT	relaxation techniques
R.T.	radiation therapy
R.T.A.	renal tubular acidosis
RTC	return to clinic
RTO	return to office
RTT	radiation therapy technician
RUE	right upper extremity
RUL	right upper lobe
R.U.L.	right upper lid
RUQ	right upper quadrant
RV	right ventricle
RVAD	Right Ventricular Assist Device
RVH	right ventricular hypertrophy
RVT	Registered Vascular Technician
Rx	treatment or treat

S

Ⓢ	Supervision
S-1, S-2	1st sacral vertebrae, etc.
S_1 S_2	heart sounds
$\bar{s}$ or w/o	without
S.A.	spontaneous aerosol
SA	sino atrial
SAH	sub arachnoid hemorrhage
SAQ	short arc quads
SAS	see assessment sheet
SB	sinus bradycardia
(SB)	**side bend**
SBE	sub-acute bacterial endocarditis
SBO	small bowel obstruction
S/CLAV	supraclavicular region
SC	Surgical Center
SCD	sequential compression device
SCUF	**Slow continuous ultra filtration**
SCUF-D	**Slow continuous ultra filtration w/Dialysis**
s/d	systolic/diastolic
SD	straight drain
SDP	single donor platelets
SDS	Same Day Surgery
SDSO	Same Day Surgery Overnight
sec	seconds
s/ed	end systolic
sed	sedimentation
sed. rate	sedimentation rate
SEMI	subendocardial myocardial infarction
SFA	superficial femoral artery
SG catheter	Swan Ganz
(SG)	**side glide**
SGOT	serum glutamic-oxaloacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SH	social history
SHHS	South Hills Health Systems
SI	sacro iliac
S.I.	stroke index
SIADH	syndrome of inappropriate antidiuretic hormone
SICU	Surgical Intensive Care Unit
sig.	signify or label
SIM	simulator
SIMV	synchronous intermittent mandatory ventilation
s.l.	sublingual
SLB	short leg brace
SLE	systemic lupus erythematosus
SLR	straight leg raise
SLS	single leg stance
sm	small

SMR	submucous resection
SN	student nurse
SNA	student nurse anesthetist
SNQ	superior nasal quadrant
SOB	short of breath
soln	solution
S/O	signs of
SOM	secondary otitis media
SOS	sacrament of the sick
sos	if necessary
SP	self pay
sp	spinal
S/P	status post
s.p.	suprapubic
SP Cord	spinal cord
SPA	salt poor albumin
spans.	spansules
sp.gr.	specific gravity
SPEP/UPEP	serum protein electrophoresis/urine protein electrophoresis
SPMU	Special Procedures Medical Unit
SPT	Student Physical Therapist
SQ, subc, subq	subcutaneous
sq. cm.	square centimeter
SR	sinus rhythm
SROM	**Self range of motion**
SS	Social Service
ss	one half
s/o	signs/symptoms
S.S.E.	soapsuds enema
SSEP	somatosensory evoked potentials
ST	sinus tachycardia
STAT	immediately; at once
STD	standard
STETH	stethoscope
STM	short-term memory
STQ	superior temporal quadrant
struct	structure
STSG	split thickness skin graft
subj	subjective
sub cut.	subcutaneously
subling.	sublingual (under the tongue)
sup	superior
supp.	suppository
surg	surgery
sum	symptoms
SVC	superior vena cava
SVT	supraventricular tachycardia
Sym, sx	symptoms

T

T or temp	temperature
T cells	thymic dependent lymphocytes
T & A	tonsils and adenoids
T & CM	type and cross match (blood)
TAH	total abdominal hysterectomy
TB or TBC	tuberculosis
TBI	total body irradiation
TBSB	total body surface burned
Tbs. or tbsp	tablespoon
T & C	type and cross
T & CM	type and cross match (blood)
T-C pO_2	transcutaneous partial pressure of oxygen
TC-99m	Microcurie
TCN	tetracycline
T/D Bili	**Total & Direct Bilirubin**
TDWB	touch down weight bearing
TENS	transcutaneous electrical nerve stimulation
Th-201	Thallium - 201
THC	tetrahydrocannabinol
THR	total hip replacement
TIA	transient ischemic attacks
tib/fib	tibia and fibula
TIBC	total iron binding capacity
tib/fib	tibia and fibula
tid	three times a day
TKA	**total knee arthroplasty**
TKR	total knee replacement
TLD	thermo luminescent dosimetry
TLI	total lymphoid irradiation
TLSO	**Thoraco-lumbar support orthotic**
TM	tympanic membrane
TMJ's	temporomandibular joints
TNTC	too numerous to count
TOBRA	tobramycin
tomo	tomogram
TP	total protein
TPN	total parental nutrition
TPR	temperature-pulse-respiration
tr	trace
trach	tracheostomy
TRH	protirelin (Thypinone, Relefact) (thyroid-releasing hormone)
troch.	troche, lozenge
TSH	thyroid stimulating hormone
tsp	teaspoonful
T-spine	thoracic spine
TT	thrombin time

TUR	transurethral resection
TURP	transurethral resection of prostate
TWE	tap water enema
Tx	traction
TX	transplant

U

U	units
UA	urinalysis
U/ml	units per milliliter
μCi	microcurie
UCD	usual childhood diseases
UE	upper extremity
UGI	upper gastrointestinal
ug/ml	micrograms per milliliter
UK	unknown
μM	micro molar
ung	ointment
Unh	unenhanced
unilat	unilateral
UOQ	upper outer quadrant
UPMC	University of Pittsburgh Medical Center
UPTD	unit pulmonary toxic dose
UR	Utilization Review
URI	upper respiratory infection
USN	ultrasonic rebulization (Nebulizer)
UTI	urinary tract infection
U.V.	ultra violet

V

V	velocity
V-wave	V wave
Va	alveolar ventilation
V.A.	visual acuity
VA	Veteran's Administration
VAD	Ventricular Assist Device
vag.	vaginal
vag. hyst.	vaginal hysterectomy
VAMC	Veteran's Administrative Medical Center
vasc	vascular
VC	verbal cues
vc	vital capacity

VCD	Visual conflict dome
VCG	vector cardiogram
VD	veneral disease
V_D	dead space
VDRL	Veneral Disease Research Laboratory (test for syphilis)
V_D / V_T	physiologic dead space to tidal volume ratio
V_E	minute ventilation (exhaled minute volume)
vent.	ventilation
VEP	visual evoked potential
VER	visual evoked response
vert	vertebral
V-Fib	ventricular fibrillation
VF's	visual fields
VG	ventrogluteal
visc	visceral
VM	venti mask
VNA	Visiting Nurse Association
VO	verbal order
V.O.D.	veno-occlusive disease
vol.	volume
vol pump	volumetric pump
VOR	vestibulo-ocular reflex
VP-16	etoposide (Ve-Pesid)
VP shunt	ventricular peritoneal shunt
V/Q scan	ventilation profusion
vs	vital signs (BP, P., and R.)
VSD	ventricular septal defect
vss	vital signs stable
V_T	tidal volume
V-tach	ventricular tachycardia

===

W

W	white
W & D	warm and dry
W - D	wet to dry
wa	while awake
w/c	wheelchair
WB	weight bearing
WBAT	weight bearing as tolerated
WBC	white blood cells or count
WC	Workmen's compensation
WDWN	well developed well nourished
WFL	Within Functional Limits
WNL	within normal limits
W/O	wide open

wp	whirlpool
WPIC	Western Psychiatric Inst. & Clinic
WRBC	washed red blood cells
wt	weight
W/U	work up

==

X

x	times
Xe-133	Xenon
Xfers	Transfers
XRT	x-ray therapy
XT	exotropia

==

Y

y/o	year old
YPC	yag posterior capsulotomy
yr	year
YTD	year to date

==

3L CVP	triple lumen CVP
17 OHCS	17 hydroxycorticosteroid

Original: 06/25/92
Revised: 08/04/92, 12/1/92, 12/23/93

SYMBOLS

approximately	≈
at	@
change	Δ
check list; checked	✓
degree	°
depressed or below, downgoing down, decreased	↓
death	†
elevated or above upgoing; up; increased	↑
female	♀
greater than	>
infinity	∞
less than	∠
male	♂
minus, negative	⊖
plus or positive	⊕
psychological	ψ
secondary	2°
to	→
equal to	=
not equal to	≠
rotation	↷

ADDENDUM TO APPROVED ABBREVIATIONS LIST

bpm	beats per minute
CV	Cardiovascular
FA	forearm
ML	midline
SaO_2	Saturated Oxygen/Oxygen Saturation
SBP	Systolic Blood Pressure
tab	Tablet
tabs	Tablets
TL	Triple Lumen
uf	Unifocal
≤	Less than or equal to
≥	Greater than or equal to

Approved by Medical Records Committee 3/94

PA CXR	Posterior/Anterior Chest X-ray
LWBS	Left Without Being Seen

Approved by Medical Records Committee 4/94

S.O.A.P. Format for Writing Contact Sheets

Subjective: Your subjective impressions of the client, i.e., appearance, mood and affect, mental status, motivation, receptivity to engagement/rapport/session activities; symptom/clinical presentation and changes therein.

Example Statements:

1. Patient arrived on time, casually dressed, neatly groomed, dysphoric and occasionally tearful throughout session; psychomotor slowing and response latency evident, described self as feeling "helpless and hopeless" but firmly denied SI/intent/plan.

2. 20 minutes late, poorly groomed with strong body odor; mood/affect/energy all WNL; eager to engage in discussion of educational possibilities.

Objective: Objectively, the content of the session, i.e.:

1. educational and employment hxs. discussed at length
2. vocational assessment begun with administration of academic achievement and occupational interest measures
3. treatment plan goals were discussed and agreed upon
4. impact of earned income upon various benefits was discussed
5. sample employment application was completed

Assessment: Your assessment of the situation, i.e.:

1. appears to be experiencing prodromal sxs.
2. could benefit from vocational assessment and counseling, R/O LD
3. could benefit from assistance in job seeking skills
4. could benefit from increased opportunities for social interaction and peer support

Plan: Plan of action derived from S, O, and A above, i.e.,

1. encourage consultation with primary clinician ASAP, consider decrease from full- to part-time status in college
2. begin psychoeducational assessment and request specialized assessment through NARS to R/O LD
3. begin same, pt. to complete sample job application for next session
4. referral to Renaissance Center discussed and agreed upon

University of Pittsburgh Medical Center

Western Psychiatric Institute & Clinic
3811 O'Hara Street, Pittsburgh, PA 15213-3241

CONSENT FOR RELEASE OF INFORMATION

(All parts of this form must be completed in compliance with the revised regulations pursuant to the Mental Health Procedures Act)

I hereby authorize ______________________________ to release information
(name of facility, agency, school or person)

from the records of ______________________________ / ______________
(name of patient) (birthdate)

For the purpose of ______________________________.

The information to be released is:

- ____ Psychiatric Evaluation
- ____ Medical History
- ____ Social History
- ____ Discharge Summary
- ____ Course of Treatment
- ____ Treatment Recommendations
- ____ Lab Reports
- ____ Neurologicals
- ____ Medications
- ____ Psychologicals/Achievement Tests (Date(s): ______________)
- ____ Developmental History
- ____ Academic/School Records
- ____ Attendance Records
- ____ Teachers' Observations
- ____ Complete Behavior Checklist (attached)
- ____ Mother's Prenatal Records
- ____ Summary of Hospitalization (Date: ______________)
- ____ Birth Records

____ Other ______________________________

HIV-related information and drug and alcohol information contained in the parts of the record indicated above will be released through this consent unless otherwise indicated. ☐ Do not release.

PLEASE FORWARD INFORMATION TO ATTENTION OF: ______________________________
(name of facility, agency, or person)

____
____
(address)

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for 90 days after the date of my signature, unless specified below. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon.

This consent shall be in effect from ______________ until ______________.

______________ Date of Signature
______________ Signature of Patient (14 years of age or older)

______________ Signature of Staff Member
______________ Signature of Parent - Legal Guardian - Authorized Representative (when applicable)

ORAL CONSENT
(Not Applicable to HIV-Related Information)

For Persons Physically Unable to Provide a Signature

I witnessed that the person understood the nature of this release and freely gave his/her oral consent. (Two witnesses are required.)

______________ Date of Signature
______________ Signature of Witness

______________ Date of Signature
______________ Signature of Witness

Item #05916 Form #1495-0000-0892

AGREEMENT TO CONTACT ADULT PATIENT'S FRIEND/RELATIVE

WPIC recognizes and respects the patient's right to confidentiality.

However, if during your treatment here at WPIC, we feel that your illness would interfere with the course of your treatment and welfare, to the point that we would become concerned about you, we would like you to list friends or relatives we could contact (in compliance with applicable Pennsylvania law) to see if you are alright.

We would possibly contact your friend/relative if:

- you are missing appointments without notifying us and we cannot reach you either by phone or mail
- we are concerned that you may be suicidal

We do not intend to call your friend or relative unless we feel it is absolutely necessary.

Name:______________________________ Relationship: __________

Address: ____

Telephone number: Home ____________ Work ____________

Name:______________________________ Relationship: __________

Address: ____

Telephone number: Home ____________ Work ____________

Name:______________________________ Relationship: __________

Address: ____

Telephone number: Home ____________ Work ____________

* *

I have read the above and agree to voluntarily provide this information.

Date: __________

Patient Signature: ______________________________ Pt. #__________

Clinician: ______________________________
9/90

University of Pittsburgh

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

CONSENT FORM

(To be completed by the Responsible Clinician)

Western Psychiatric Institute and Clinic (WPIC) produces audio/visual materials for educational and research purposes as well as for therapeutic reasons. These materials are distributed for professional use and are not therefore intended for general public consumption.

The purpose of this form is to obtain your permission as (a patient) (the guardian of a patient) (the parent(s) of a patient) at WPIC to produce (photographs) (sound motion pictures) (closed circuit television interviews) (sound video tapes) (other -- specify: ______________________) which involve patient participation and to distribute the results for professional use in the furtherance of medical science, research, education, practice and knowledge. The name(s) of patient(s) (will) (will not) be included. Illness, problems and treatment will be included. Even if the patient's name is not used, you should understand that it is possible for the patient to be recognized by someone from the sound of voice, mannerisms or physicial characteristics.

The recordings or photo session will take place on ________(date) at ______________(location). The following equipment will be used: (still camera) (movie camera) (television camera) (tape recorder) (other -- specify: ____________________). The clinician directly responsible for the activity is __________________________________(name) and he or she will explain this form to you prior to your signing it. The WPIC employee technician directly responsible for the production is ______________________(name). Both of these people will be present at the production to answer any questions which participating patients may have. It is expected that ________(number) patients and ___________(number) authorized WPIC staff members will be present at the production.

Upon completion of the production, including editing, the results will be processed as a resource for future professional use both inside and outside of WPIC including other medical and educational institutions and professional publication and presentations. The results become the property of WPIC and any other professional organization to which WPIC may distribute them.

By signing this form you are agreeing to the following items:

1. A complete understanding of the information provided above and the fact that your willingness or unwillingness to sign this form will in no way influence the provision of health care to you or the patient you represent at WPIC.
2. Participation without financial remuneration in the applicable patient activity identified above.

3. Production by WPIC of the activity in the manner indicated above.

4. Ownership of production results by WPIC.

5. Distribution of production results inside and outside of WPIC for professional use in the furtherance of medical science, research, education, practice and knowledge, and not for general public use.

6. Reasonable control by WPIC over the storage and distribution of the results for purposes stated.

7. Release of WPIC, the University of Pittsburgh and its employees, from any claims for damages resulting from dissemination, distribution, display, reproduction, production, publication or showing of the audio/visual production described above.

8. Production by WPIC in the manner indicated above, but discussion by you with therapist(s) after production but before use, release and distribution of production results for the purposes stated above. My second signature on this form is my authorization for the use, release and distribution of production results for the purpose stated above. If I do not provide such authorization, the production results will be destroyed.

I have read all of the above statements and I have had the opportunity to ask questions. I fully understand them and I voluntarily consent therein.

____
Printed Name of Patient

Date of Signature____________

____
Signature of Patient (if applicable)

Date of Signature____________

____
Signature of Parent(s) or Guardian (if applicable)

____
Printed Name of Parent(s) or Guardian (if applicable)

I certify that I have explained the meaning of this form to the above Signatories.

Date of Signature____________

____
Signature of Responsible Clinician

I have discussed production results with______________________(therapist). I authorize their use, release and distribution for the purpose stated above.

Date of Signature____________

____
Signature

____
Signature of Witness

UNIVERSITY OF PITTSBURGH
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

INITIAL EVALUATION FORM
CLINICAL SECTION
(5/14/82 Revision)

Name: ____________________

WPIC NUMBER ☐☐☐☐☐

Date: ______ ______ ______
m d y

Evaluation Setting: ____________________

☐ **Previous** *(latest)* **IEF completed at WPIC: Evaluation Setting:** ____________________ Date: ____/____/____

REASONS FOR REFERRAL AND EVALUATION: *(Including chief complaint and sources of information)*

HISTORY OF PRESENT ILLNESS *(Start with history of current episode. Then in additional paragraphs describe previous episodes of the present illness. For each episode narrate onset and course of precipitating/maintaining factors, symptoms, repercussion on social functioning and treatment received. Include use of alcohol and other drugs and evidence of dangerousness to self and others.)*

WPIC NUMBER ☐☐☐☐☐

HISTORY OF OTHER PSYCHIATRIC DISORDERS

(Manifestations and treatment of currently inactive psychiatric disorders, and of personality disorders which preceded present illness, to be used as background information)

PSYCHIATRIC HISTORY MARKERS

(Use question marks for unknown months, days or years)

1 REGARDING AXIS I PRIMARY DIAGNOSIS (if any) ☐ None

a Approximate date of onset of current episode ____ m ____ d ____ y

b Approximate date of onset of first episode of this psychiatric illness ____ m ____ d ____ y

c Overall trend since onset of this psychiatric illness

☐ Improving ☐ Stationary ☐ Worsening ☐ Unknown

d Episodicity of this psychiatric illness

☐ Continuous or single episode ☐ Fluctuating without clear-cut episodes ☐ With clear-cut episodes ☐ Unknown

2 APPROXIMATE DATE OF ONSET OF AXIS I SECONDARY DIAGNOSIS (if any)
____ m ____ d ____ y ☐ None

3 DATE OF FIRST PSYCHIATRIC OUTPATIENT CARE EVER RECEIVED
____ m ____ d ____ y ☐ None

4 DATE OF FIRST PSYCHIATRIC HOSPITALIZATION EVER
____ m ____ d ____ y ☐ None

5 NUMBER OF WEEKS OF PSYCHIATRIC HOSPITALIZATION DURING THE PAST 12 MONTHS ____________ ☐ Unknown

6 MODALITIES OF MENTAL HEALTH TREATMENT RECEIVED DURING THE PAST 12 MONTHS (check all applicable)

- ☐ None
- ☐ Individual psychotherapy
- ☐ Group psychotherapy
- ☐ Family therapy
- ☐ Specific behavioral techniques
- ☐ Neuroleptics
- ☐ Minor tranquilizers
- ☐ Antidepressants
- ☐ Lithium
- ☐ Stimulants
- ☐ Anti-Parkinsonian medication
- ☐ Anticonvulsants
- ☐ Other/Unspecified medication
- ☐ ECT
- ☐ Other/Unspecified modalities

7 ☐ RECENT SIGNIFICANT PSYCHOTROPIC MEDICATION CHANGE OR DISCONTINUATION

SYMPTOM INVENTORY

	NEVER PRESENT	PAST	CURRENT EPISODE	DURING INTERVIEW
		N: Absent Y: Present ?: Unknown	N: Absent 1: Mild 2: Moderate 3: Severe ?: Unknown	[illegible] as present
1 HYPOSOMNIA difficulty falling or staying asleep and or early morning awakening	☐	N Y ?	N 1 2 3 ?	Y
2 HYPERSOMNIA excessive amount of sleep	☐	N Y ?	N 1 2 3 ?	Y
3 APPETITE DECREASED and food refusal	☐	N Y ?	N 1 2 3 ?	Y
4 APPETITE INCREASED	☐	N Y ?	N 1 2 3 ?	Y
5 WEIGHT DECREASED	☐	N Y ?	N 1 2 3 ?	Y
6 WEIGHT INCREASED	☐	N Y ?	N 1 2 3 ?	Y
7 DECREASED LIBIDO lack of sexual interest or activity	☐	N Y ?	N 1 2 3 ?	Y
8 INCREASED LIBIDO	☐	N Y ?	N 1 2 3 ?	Y
9 DISTURBED SEXUAL PERFORMANCE impotence inhibited orgasm premature ejaculation dyspareunia	☐	N Y ?	N 1 2 3 ?	Y
10 ABNORMAL SEXUAL OBJECT OR SITUATION paraphilias	☐	N Y ?	N 1 2 3 ?	Y
11 SEXUAL IDENTITY PROBLEMS	☐	N Y ?	N 1 2 3 ?	Y
12 ALCOHOL USE of concern to individual or significant other	☐	N Y ?	N 1 2 3 ?	Y
13 USE OF OTHER C N S DEPRESSANTS barbiturates other hypnotics minor tranquilizers	☐	N Y ?	N 1 2 3 ?	[illegible]
14 USE OF OTHER DRUGS stimulants narcotic analgesics marijuana hallucinogens cocaine	☐	N Y ?	N 1 2 3 ?	Y
15 VIOLENT BEHAVIOR forceful aggressiveness assaultiveness destructiveness	☐	N Y ?	N 1 2 3 ?	Y
16 IMPULSIVITY poor impulse control	☐	N Y ?	N 1 2 3 ?	Y
17 OTHER ANTISOCIAL BEHAVIOR cheating, stealing irresponsibility lying	☐	N Y ?	N 1 2 3 ?	Y
18 HYPERSENSITIVITY TO CRITICISM or rejection	☐	N Y ?	N 1 2 3 ?	Y
19 EMOTIONAL DISTANCE OR COLDNESS limited capacity to form social relationships	☐	N Y ?	N 1 2 3 ?	Y
20 ECCENTRICITY oddities in thinking perception speech and behavior	☐	N Y ?	N 1 2 3 ?	Y
21 OVERLY DRAMATIC BEHAVIOR attention-seeking and intensely expressed reactive behavior	☐	N Y ?	N 1 2 3 ?	Y
22 SELF CENTEREDNESS grandiose sense and fantasies of self-importance and entitlement	☐	N Y ?	N 1 2 3 ?	Y
23 UNSTABLE AND INTENSE RELATIONSHIPS	☐	N Y ?	N 1 2 3 ?	Y
24 UNDUE DEPENDENCE ON OTHERS allowing others to assume responsibility for self	☐	N Y ?	N 1 2 3 ?	Y
25 UNDUE PERFECTIONISM overconcern with details and work demandingness	☐	N Y ?	N 1 2 3 ?	Y
26 INTENTIONAL INEFFECTIVENESS indirect resistance to demands for performance	☐	N Y ?	N 1 2 3 ?	Y

WPIC NUMBER ☐☐☐☐☐

MENTAL STATUS OBSERVATIONS *(Describe here positive and pertinent negative manifestations of current episode with focus on what is shown during the interview. Manifestations present only in the past should be described in the psychiatric history but not here)*

I. General Appearance and Behavior

II. Speech and Thought Rate and Pattern

III. Mood and Affect

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SYMPTOM INVENTORY (continuation)

	NEVER PRESENT	PAST N=Absent Y=Present ?=Unknown	CURRENT EPISODE N=Absent 1=Mild 2=Moderate 3=Severe ?=Unknown	DURING INTERVIEW Y=Observed or reported as present
27 DECREASED MOTOR ACTIVITY	☐	N Y ?	N 1 2 3 ?	Y
28 INCREASED MOTOR ACTIVITY restlessness agitation	☐	N Y ?	N 1 2 3 ?	Y
29 SOCIAL WITHDRAWAL lack of spontaneous interaction seclusiveness	☐	N Y ?	N 1 2 3 ?	Y
30 SELF-NEGLECT lack of attention to cleanliness and clothing	☐	N Y ?	N 1 2 3 ?	Y
31 BIZARRE BEHAVIOR idiosyncratic appearance and conduct mannerisms and posturing	☐	N Y ?	N 1 2 3 ?	Y
32 HOSTILITY belligerence unco-operativeness	☐	N Y ?	N 1 2 3 ?	Y
33 DISSOCIATIVE SYMPTOMS narrowing of consciousness	☐	N Y ?	N 1 2 3 ?	Y
34 CONVERSION SYMPTOMS functional paralysis anesthesia seizures etc	☐	N Y ?	N 1 2 3 ?	Y
35 SLOWED SPEECH AND THOUGHT	☐	N Y ?	N 1 2 3 ?	Y
36 SPEECH PRESSURE OR FLIGHT OF IDEAS speech rapidity and dominance or abrupt topic changes based on understandable associations distracting stimuli or word plays	☐	N Y ?	N 1 2 3 ?	Y
37 THOUGHT PROCESS DISORGANIZATION loose associations incoherence blocking	☐	N Y ?	N 1 2 3 ?	Y
38 GENERAL ANXIETY motor tension autonomic hyperactivity apprehensive expectation and scanning	☐	N Y ?	N 1 2 3 ?	Y
39 PANIC ATTACKS discrete periods of sudden onset of intense apprehension or terror with autonomic symptoms	☐	N Y ?	N 1 2 3 ?	Y
40 SITUATIONAL ANXIETY OR PHOBIAS persistent irrational fear of an object or situation	☐	N Y ?	N 1 2 3 ?	Y
41 DEPRESSED MOOD sadness dejection crying	☐	N Y ?	N 1 2 3 ?	Y
42 LOW SELF-ESTEEM	☐	N Y ?	N 1 2 3 ?	Y
43 LABILITY OF MOOD repeated rapid shifts in mood	☐	N Y ?	N 1 2 3 ?	Y
44 ELATED MOOD euphoria excitement expansiveness	☐	N Y ?	N 1 2 3 ?	Y
45 FLAT or INCONGRUOUS AFFECT inappropriate for content of speech	☐	N Y ?	N 1 2 3 ?	Y

WPIC NUMBER ☐☐☐☐☐

OPTIONAL

COGNITIVE FUNCTIONING INVENTORY

Evaluate each item on the basis of performance of the subject on the various questions or tests listed under each heading. Numbers within parentheses identify test cards to be used. For each subitem or test used, make a (✓) for correct or an (X) for incorrect, in the space provided. Make allowances for native language and cultural factors. Impairment rating scale: **N** = Absent: fully correct or a minor error; **1** = Mild: mostly correct with a few minor errors; **2** = Moderate: a gross error or several minor errors; **3** = Severe: gross and multiple errors; **?** = Unknown: uncertain or not tested

Item	**IMPAIRMENT**				
	ABSENT/ NORMAL	**MILD**	**MODERATE**	**SEVERE**	**UNKNOWN/ UNCERTAIN**
1 **Level of consciousness** (N=awake & alert; 1=awake but inattentive; 2=lethargic; 3=stuporous or comatose)	N	1	2	3	?
2 **Orientation to person** name ____ age ____ date of birth ____	N	1	2	3	?
3 **Orientation to time** day of week ____ day ____ month ____ year ____ season ____ time of day ____	N	1	2	3	?
4 **Orientation to place** building ____ type of institution ____ (e.g. hospital/hotel) floor ____ city ____ part of city ____	N	1	2	3	?
5 **Learning and memory** repeat four words (brown, cold, flower, car) allow up to 4 trials, discontinue after 2 correct trials (Trials 1 ____, 2 ____, 3 ____, 4 ____) Recall after 2 minutes ____ and 10 minutes ____ Expose drawing for 10 seconds (1) draw from memory ____ recall after 15 minutes ____ recall at end of session ____ Recall story (2) ____ recall at end of session ____	N	1	2	3	?
6 **Remote memory and general information** president ____ before him ____ before him ____ governor ____ major events in past 10 years (e.g. Watergate) ____ name familiar faces (3-7) ____ weeks in year ____	N	1	2	3	?
7 **Concentration and attention span** tap for every A (8) ____ digit span (9) forward ____ backward ____ starting at 1 count by 3 ____	N	1	2	3	?
8 **Language function** spontaneous speech (fluency ____, grammar ____ content ____), comprehension ____ naming colors (10) ____, objects (11-23) ____ write name ____, address ____, sentence ____ numbers ____	N	1	2	3	?
9 **Constructional ability** copy drawing (24-25) ____ draw clock ____ set time to 20 to 1 (or 12 40) ____ copy pipe (26) ____	N	1	2	3	?
10 **Abstraction** similarities (27) ____, proverbs (28) ____	N	1	2	3	?
11 **Judgment** (29) ____	N	1	2	3	?
12 **Specific cerebral dysfunction** (test only if specifically indicated) frontal lobe tests (30) ____ right/left orientation(31) ____, praxis (32) ____ arithmetic (33) ____, reading (34-36) ____ repetition of words and phrases (37) ____ language comprehension (38) ____	N	1	2	3	?

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☐ Check if all items 1 - 12 were completed in full using all cards involved

WPIC NUMBER ☐☐☐☐☐

IV. Thought content and Perception

V. Sensorium, Orientation, Intellectual Functions and Insight

SYMPTOM INVENTORY (continuation)

		NEVER PRESENT	PAST	CURRENT EPISODE	DURING INTERVIEW
			N=Absent Y=Present ?=Unknown	N=Absent 1=Mild 2=Moderate 3=Severe ?=Unknown	Y=Observed or reported as present
46	**SUSPICIOUSNESS** feelings that everything is not as it should be inappropriate interpretiveness hyper-vigilance guardedness	☐	N Y ?	N 1 2 3 ?	Y
47	**SOMATIC PREOCCUPATION** hypochondriasis	☐	N Y ?	N 1 2 3 ?	Y
48	**SUICIDAL INDICATORS** death wishes suicide ideas or attempts	☐	N Y ?	N 1 2 3 ?	Y
49	**HOMICIDAL IDEATION**	☐	N Y ?	N 1 2 3 ?	Y
50	**HOMICIDAL BEHAVIOR**	☐	N Y ?	N 1 2 3 ?	Y
51	**OBSESSIONS AND COMPULSIONS** repetitive, intrusive thoughts or behavior experienced against conscious resistance	☐	N Y ?	N 1 2 3 ?	Y
52	**DEPERSONALIZATION** experiencing self and surroundings as unreal	☐	N Y ?	N 1 2 3 ?	Y
53	**SCHNEIDERIAN SYMPTOMS** voices arguing or commenting on one's actions or speaking thoughts aloud, somatic passivity, thought withdrawal, insertion or broadcasting "made" feelings, impulses, or acts, primary delusional perception	☐	N Y ?	N 1 2 3 ?	Y
54	**OTHER AUDITORY HALLUCINATIONS**	☐	N Y ?	N 1 2 3 ?	Y
55	**VISUAL HALLUCINATIONS**	☐	N Y ?	N 1 2 3 ?	Y
56	**OTHER HALLUCINATIONS** smell, taste, touch	☐	N Y ?	N 1 2 3 ?	Y
57	**DELUSIONS OF REFERENCE, PERSECUTION, JEALOUSY OR GRANDIOSITY**	☐	N Y ?	N 1 2 3 ?	Y
58	**DEPRESSIVE DELUSIONS OR HALLUCINATIONS** nihilistic or derogatory content	☐	N Y ?	N 1 2 3 ?	Y
59	**OTHER DELUSIONS**	☐	N Y ?	N 1 2 3 ?	Y
60	**IMPAIRED SENSORIUM AND ORIENTATION** to time, place and person	☐	N Y ?	N 1 2 3 ?	Y
61	**ACQUIRED INTELLECTUAL IMPAIRMENT** deficit in memory, calculation, knowledge, judgement	☐	N Y ?	N 1 2 3 ?	Y
62	**DEVELOPMENTAL INTELLECTUAL DEFICIT**	☐	N Y ?	N 1 2 3 ?	Y
63	**POOR CONCENTRATION** poor attention span, distractibility	☐	N Y ?	N 1 2 3 ?	Y
64	**LACK OF INSIGHT** about presence and nature of psychopathology	☐	N Y ?	N 1 2 3 ?	Y

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WPIC NUMBER ☐☐☐☐☐

SUPPLEMENTARY MENTAL STATUS OBSERVATIONS AND SYMPTOM EVALUATION FOR CHILDREN AND ADOLESCENTS

VI Conduct and Emotional Problems

VII. Problems with Physical Manifestations

VIII. Developmental Problems

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	NEVER PRESENT	PAST N=Absent Y=Present ?=Unknown	CURRENT EPISODE N=Absent 1=Mild 2=Moderate 3=Severe ?=Unknown	DURING INTERVIEW Y=[illegible] or [illegible] as present
65 FIRE SETTING	☐	N Y ?	N 1 2 3 ?	Y
66 TRUANCY	☐	N Y ?	N 1 2 3 ?	Y
67 RUNNING AWAY	☐	N Y ?	N 1 2 3 ?	Y
68 DISOBEDIENCE persistent rule breaking, defiance to authority	☐	N Y ?	N 1 2 3 ?	Y
69 TEMPER TANTRUMS screaming, breath-holding attacks	☐	N Y ?	N 1 2 3 ?	Y
70 SCHOOL REFUSAL	☐	N Y ?	N 1 2 3 ?	Y
71 ELECTIVE MUTISM refusal to speak in social situations	☐	N Y ?	N 1 2 3 ?	Y
72 DISTORTION OF BODY IMAGE	☐	N Y ?	N 1 2 3 ?	Y
73 FEAR OF OBESITY	☐	N Y ?	N 1 2 3 ?	Y
74 PICA persistent eating of non-nutritive substances	☐	N Y ?	N 1 2 3 ?	Y
75 TICS involuntary rapid movements or productions of noises or words	☐	N Y ?	N 1 2 3 ?	Y
76 STUTTERING	☐	N Y ?	N 1 2 3 ?	Y
77 ENURESIS	☐	N Y ?	N 1 2 3 ?	Y
78 ENCOPRESIS	☐	N Y ?	N 1 2 3 ?	Y
79 PARASOMNIAS e.g. sleepwalking, night terrors	☐	N Y ?	N 1 2 3 ?	Y
80 AUTISTIC WITHDRAWAL lack of responsiveness to other people	☐	N Y ?	N 1 2 3 ?	Y
81 RESISTANCE TO CHANGE IN THE ENVIRONMENT	☐	N Y ?	N 1 2 3 ?	Y
82 PECULIAR SPEECH PATTERN pronominal reversal, metaphoric language, echolalia, bizarre rhythm or intonation of speech	☐	N Y ?	N 1 2 3 ?	Y
83 SELF-ABUSIVE BEHAVIOR self mutilation, biting or hitting self, head banging	☐	N Y ?	N 1 2 3 ?	Y
84 ODDITIES OF MOTOR BEHAVIOR peculiar posturing, peculiar hand or finger movements, abnormal repetitive movements, walking on tiptoe etc	☐	N Y ?	N 1 2 3 ?	Y
85 DELAYED LANGUAGE ACQUISITION difficulty in comprehending or expressing oral language	☐	N Y ?	N 1 2 3 ?	Y
86 DIFFICULTY IN ARTICULATION of speech sounds such as r, sh, f, z, l or ch	☐	N Y ?	N 1 2 3 ?	Y

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WPIC NUMBER ☐☐☐☐☐

FAMILY HISTORY *(Past and current psychiatric and chronic major physical disorders in the family. First ask about family history of mental/emotional illness in general; then for specific relatives, inquire about a positive history of untreated psychiatric disorder, psychiatric ambulatory care and hospitalization, completed suicide, and type of psychiatric disorder such as depression, alcoholism, and schizophrenia; and finally inquire about chronic major physical disorders, including those that may have caused deaths.)*

For each group of relatives. circle all applicable options

RELATIVES	PSYCHIATRIC DISORDERS U:Untreated O:With outpatient care H:with hospitalization C:completed suicide D:Depression A:Alcoholism S:Schizophrenia							Chronic Major Physical Dis-orders y:yes	Not Known
FATHER	U	O	H	C	D	A	S	Y	?
MOTHER	U	O	H	C	D	A	S	Y	?
SIBLINGS	U	O	H	C	D	A	S	Y	?
OFFSPRING	U	O	H	C	D	A	S	Y	?
EXTENDED FAMILY	U	O	H	C	D	A	S	Y	?

☐ Family with three or more members with any specifically reported psychiatric and/or neurologic disorders

PERSONAL AND SOCIAL HISTORY *(Developmental, educational, marital, sexual, military, occupational, and legal history. Current family structure and social support system* [availability of confidant, group and community support]. *Assets* [talents, adaptive means of coping, motivation for treatment, etc.] *useful for treatment planning.)*

	NO	YES	NOT KNOWN
1 Perinatal problems	N	Y	?
2 Developmental delays	N	Y	?
3 Broken family or serious family problems while growing up	N	Y	?
4 Academic difficulties at school	N	Y	?
5 Behavioral, discipline and social problems at school	N	Y	?
6 Difficulties during military service or less than "honorable" discharge	N	Y	?
7 Considerable past periods of unemployment or poor work performance	N	Y	?
8 History of marital disharmony or divorce	N	Y	?
9 Arrests with convictions	N	Y	?
10 Lack of confidant	N	Y	?
11 Lack of supportive interpersonal and community resources	N	Y	?

WPIC NUMBER ☐☐☐☐☐

MEDICAL HISTORY *(Through anamnesis and review of systems identify major non-psychiatric illnesses and injuries giving particular attention to respiratory, cardiovascular, gastro-intestinal, genito-urinary, gyneco-obstetric, endocrine and neurological disorders, and list them in order of date of onset, indicating associated hospitalizations and operations. For children and adolescents also record information on abnormal growth and pubertal state.)*

CURRENT PHYSICAL PROBLEMS	NO	YES	NOT KNOWN
1. Respiratory (rhinitis, sinusitis, pharangitis, tonsillitis, shortness of breath, chronic cough, hemoptysis, wheezing)	N	Y	?
2. Cardiovascular (chest pain, palpitations, high blood pressure, heart attack/failure, edema)	N	Y	?
3. Gastro-intestinal (appetite/weight changes, constipation, diarrhea, abdominal pains, melena, bright red rectal bleeding, jaundice, liver/bladder problems)	N	Y	?
4. Genito-Urinary (dysuria, frequency, nocturia, hematuria, flank pain, menstrual problems)	N	Y	?
5. Endocrine (diabetes, thyroid disease, galactorrhea)	N	Y	?
6. Neurologic-Muscular (headaches, lightheadedness, syncope, diplopia, weakness, paresthesias, convulsions, stroke, chronic neuromuscular handicaps)	N	Y	?
7. Miscellaneous (joint, back or muscle pain, arthritis, anemia, bruising)	N	Y	?

Allergies and their manifestations: ______

Latest physical examination: Date ___/___/___ (m d y) Setting ______

Current physicians: ______

Current medications and doses: ______

PHYSICAL EXAMINATION

Vital Signs: Pulse ______ BP ___/___ ☐right arm ☐left arm Temperature ______ Respirations ______

Significant positive physical findings: ☐ No ☐ Yes ☐ Not Known

INSTRUCTIONS FOR DSM-III AXES I AND II

Axes I and II comprise the entire classification of mental disorders. Axis II includes Personality Disorders and Specific Developmental Disorders (listed within boxes on this page and on the back of page 7). All other disorders and conditions are included in Axis I.

On both Axes I and II multiple diagnoses may be made to describe the current psychiatric condition. Within each axis, diagnoses should be listed as primary, secondary and so forth, in order, with that being the focus of attention or treatment listed first.

The *Principal* diagnosis is that chiefly responsible for occasioning the evaluation or admission to clinical care. It will be assumed to be the first diagnosis on Axis I, unless the first diagnosis on Axis II is followed by "(Principal Diagnosis)".

The clinician may wish to indicate a significant degree of diagnostic uncertainty by writing "(Provisional)" following a given codable diagnosis in the main formulation section. Additionally, for each codable diagnosis, alternatives to be ruled out in a differential diagnosis process may be mentioned within the boxed sections of the diagnostic summary.

LIST OF AXES I AND II CATEGORIES AND CODES

LIST OF AXES I AND II CATEGORIES AND CODES

For most disorders, the DSM-III and ICD-9-CM codes are essentially the same. Whenever there is a substantial difference, the ICD-9-CM code is provided in parentheses after the diagnostic term. To ensure retrieval of DSM-III specificity, use always the codes to the left of the diagnostic terms. Data entry into the computer will include codes for both diagnostic systems.

The long dashes indicate the need for a fifth-digit subtype or other qualifying term.

DISORDERS USUALLY FIRST EVIDENT IN INFANCY CHILDHOOD OR ADOLESCENCE

Mental Retardation
(Code in fifth digit 1 = with other behavioral symptoms [requiring attention or treatment and that are not part of another disorder] 0 = without other behavioral symptoms.)
317 0(x) Mild mental retardation ______
318 0(x) Moderate mental retardation ______
318 1(x) Severe mental retardation ______
318 2(x) Profound mental retardation ______
319 0(x) Unspecified mental retardation ______

Attention deficit disorder
314 01 with hyperactivity
314 00 without hyperactivity
314 80 residual type

Conduct disorder
312 00 undersocialized, aggressive
312 10 undersocialized, nonaggressive
312 23 socialized, aggressive
312 21 socialized, nonaggressive
312 90 atypical

Anxiety disorders of childhood or adolescence
309 21 Separation anxiety disorder
313 21 Avoidant disorder of childhood or adolescence
313 00 Overanxious disorder

Other disorders of infancy, childhood or adolescence
313 89 Reactive attachment disorder of infancy
313 22 Schizoid disorder of childhood or adolescence
313 23 Elective mutism
313 81 Oppositional disorder
313 82 Identity disorder

Eating disorders
307 10 Anorexia nervosa
307 51 Bulimia
307 52 Pica
307 53 Rumination disorder of infancy
307 50 Atypical eating disorder

Stereotyped movement disorders
307 21 Transient tic disorder
307 22 Chronic motor tic disorder
307 23 Tourette's disorder
307 20 Atypical tic disorder
307 30 Atypical stereotyped movement disorder

Other disorders with physical manifestations
307 00 Stuttering
307 60 Functional enuresis
307 70 Functional encopresis
307 46 Sleepwalking disorder
307 49 Sleep terror disorder (307 46)

Pervasive developmental disorders
Code in fifth digit 0 = full syndrome present, 1 = residual state
299 0x Infantile autism ______
299 9x Childhood onset pervasive developmental disorder ______
299 8x Atypical ______

Specific developmental disorders
Note: These are coded on Axis II.
315 00 Developmental reading disorder
315 10 Developmental arithmetic disorder
315 31 Developmental language disorder
315 39 Developmental articulation disorder
315 50 Mixed specific developmental disorder
315 90 Atypical specific developmental disorder

ORGANIC MENTAL DISORDERS

Section 1. Organic mental disorders whose etiology or pathophysiological process is listed below (taken from the mental disorders section of ICD-9—CM).

Dementias arising in the senium and presenium

Primary degenerative dementia, senile onset
290 30 with delirium
290 20 with delusions
290 21 with depression
290 00 uncomplicated

code in fifth digit
1 = with delirium, 2 = with delusions, 3 = with depression
0 = uncomplicated
290 1x Primary degenerative dementia, presenile onset ______
290 4x Multi-infarct dementia ______

Substance induced

Alcohol
303 00 intoxication
291 40 idiosyncratic intoxication
291 80 withdrawal
291 00 withdrawal delirium
291 30 hallucinations
291 10 amnestic disorder

Code severity of dementia in fifth digit
1 = mild, 2 = moderate, 3 = severe, 0 = unspecified
291 2x Dementia associated with alcoholism ______

Barbiturate or similarly acting sedative or hypnotic
327 00 intoxication (305 40)
327 01 withdrawal (292 00)
327 02 withdrawal delirium (292 00)
327 04 amnestic disorder (292 83)

Opioid
327 10 intoxication (305 50)
327 11 withdrawal (292 00)

Cocaine
327 20 intoxication (305 60)

Amphetamine or similarly acting sympathomimetic
327 30 intoxication (305 70)
327 32 delirium (292 81)
327 35 delusional disorder (292 11)
327 31 withdrawal (292 00)

Phencyclidine (PCP) or similarly acting arycyclohexylamine
327 40 intoxication (305 90)
327 42 delirium (292 81)
327 49 mixed organic mental disorder (292 90)

Hallucinogen
327 56 hallucinosis (305 30)
327 55 delusional disorder (292 11)
327 57 affective disorder (294 84)

Cannabis
327 60 intoxication (305 20)
327 65 delusional disorder (292 11)

Tobacco
327 71 withdrawal (292 00)

Caffeine
327 80 intoxication (305 90)

Other or unspecified substance
327 90 intoxication (305 90)
327 91 withdrawal (292 00)
327 92 delirium (292 81)
327 93 dementia (292 20)
327 94 amnestic disorder (292 83)
327 95 delusional disorder (292 11)
327 96 hallucinosis (292 12)
327 97 affective disorder (292 84)
327 98 personality disorder (292 89)
327 99 atypical or mixed organic mental disorder (292 90)

Section 2. Organic brain syndromes whose etiology or pathophysiological process is either noted as an additional diagnosis from outside the mental disorders section of ICD-9-CM or is unknown.
293 00 Delirium
294 10 Dementia
294 00 Amnestic syndrome
293 81 Organic delusional syndrome
293 82 Organic hallucinosis
293 83 Organic affective syndrome
310 10 Organic personality syndrome
294 80 Atypical or mixed organic brain syndrome

WPIC NUMBER ☐☐☐☐☐

NARRATIVE ASSESSMENT SUMMARY

Evaluator's confidence in the information obtained: ☐ High ☐ Adequate ☐ Marginal ☐ Poor

PROBLEMS *(Psychopathological, physical, and social)* ☐ See separate treatment plan form	**RECOMMENDATIONS** *(Further diagnostic studies and treatment modalities. Instructions given to patient family)*

PLANS FOR FAMILY MEMBERS

☐ See separate social evaluation form

LIST OF AXES I AND II CATEGORIES AND CODES (CONTINUATION)

SUBSTANCE USE DISORDERS

Code in fifth digit 1 = continuous, 2 = episodic, 3 = in remission 0 = unspecified

305 0x	Alcohol abuse ____
303 9x	Alcohol dependence (Alcoholism), ____
305 4x	Barbiturate or similary acting sedative or hypnotic abuse
304 1x	Barbituate or similarly acting sedative or hypnotic dependence, ____
305 5x	Opioid abuse, ____
304 0x	Opioid dependence ____
305 6x	Cocaine abuse, ____
305 7x	Amphetamine or similarly acting sympathomimetic abuse, ____
304 4x	Amphetamine or similary acting sympathomimetic dependence, ____
305.9x	Phencyclidine (PCP) or similarly acting arylcyclohexylamine abuse, ____ (328 4x)
305.3x	Hallucinogen abuse, ____
305.2x	Cannabis abuse, ____
304.3x	Cannabis dependence, ____
305 1x	Tobacco dependence, ____
305 9x	Other, mixed or unspecified substance abuse, ____
304 6x	Other specified substance dependence, ____
304 9x	Unspecified substance dependence, ____
304 7x	Dependence on combination of opioid and other non alcoholic substance, ____
304.8x	Dependence on combination of substances, excluding opioids and alcohol, ____

SCHIZOPHRENIC DISORDERS

Code in fifth digit 1 = subchronic, 2 = chronic, 3 = subchronic with acute exacerbation, 4 = chronic with acute exacerbation, 5 = in remission, 0 = unspecified

	Schizophrenia,
295.1x	disorganized, ____
295.2x	catatonic, ____
295.3x	paranoid, ____
295.9x	undifferentiated, ____
295.6x	residual, ____

PARANOID DISORDERS

297.10	Paranoia
297.30	Shared paranoid disorder
298.30	Acute paranoid disorder
297.90	Atypical paranoid disorder

PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED

295.40	Schizophreniform disorder
298.80	Brief reactive psychosis
295.70	Schizoaffective disorder
298.90	Atypical psychosis

AFFECTIVE DISORDERS

Major affective disorders

Code major depressive episode in fifth digit 6 = in remission, 4 = with psychotic features (the unofficial non-ICD-9-CM fifth digit 7 may be used instead to indicate that the psychotic features are mood-incongruent), 3 = with melancholia, 2 = without melancholia, 0 = unspecified

Code manic episode in fifth digit 6 = in remission, 4 = with psychotic features (the unofficial non-ICD-9-CM fifth digit 7 may be used instead to indicate that the psychotic features are mood-incongruent), 2 = without psychotic features, 0 = unspecified

	Bipolar disorder,
296 6x	mixed ____
296 4x	manic ____
296 5x	depressed, ____
	Major depression,
296 2x	single episode, ____
296 3x	recurrent, ____

Other specific affective disorders

301 13	Cyclothymic disorder
300 40	Dysthymic disorder (or Depressive neurosis)

Atypical affective disorders

296 70	Atypical bipolar disorder
296.82	Atypical depression

ANXIETY DISORDERS

	Phobic disorders (or Phobic neuroses)
300 21	Agoraphobia with panic attacks
300.22	Agoraphobia without panic attacks
300 23	Social phobia
300.29	Simple phobia
	Anxiety states (or Anxiety neuroses)
300.01	Panic disorder
300.02	Generalized anxiety disorder
300.30	Obsessive compulsive disorder (or Obsessive compulsive neurosis)
	Post-traumatic stress disorder
308.30	acute
309.81	chronic or delayed
300.00	Atypical anxiety disorder

SOMATOFORM DISORDERS

300.81	Somatization disorder
300.11	Conversion disorder (or Hysterical neurosis, conversion type)
307.80	Psychogenic pain disorder
300.70	Hypochrondriasis (or Hypochrondriacal neurosis)
300 71	Atypical somatoform disorder (300 70)

DISSOCIATIVE DISORDERS (OR HYSTERICAL NEUROSES, DISSOCIATIVE TYPE)

300.12	Psychogenic Amnesia
300 13	Psychogenic fugue
300 14	Multiple personality
300 60	Depersonalization disorder (or depersonalization neurosis)
300 15	Atypical dissociative disorder

PSYCHOSEXUAL DISORDERS

Gender identity disorders

Indicate sexual history in the fifth digit of Transsexualism code
1 = asexual, 2 = homosexual, 3 = heterosexual,
0 = unspecified

302 5x	Transsexualism, ____
302.60	Gender identity disorder of childhood
302.85	Atypical gender identity disorder

Paraphilias

302.81	Fetishism
302.30	Transvestism
302 10	Zoophilia
302 20	Pedophilia
302 40	Exhibitionism
302.82	Voyeurism
302 83	Sexual masochism
302 84	Sexual sadism
302.90	Atypical paraphilia

Psychosexual dysfunctions

302 71	Inhibited sexual desire
302.72	Inhibited sexual excitement
302 73	Inhibited female orgasm
302 74	Inhibited male orgasm
302.75	Premature ejaculation
302 76	Functional dyspareunia
306.51	Functional vaginismus
302 70	Atypical psychosexual dysfunction

Other psychosexual disorders

302 00	Ego-dystonic homosexuality
302 89	Psychosexual disorder not elsewhere classified

FACTITIOUS DISORDERS

300 16	Factitious disorder with psychological symptoms
301 51	Chronic factitious disorder with physical sympto
300.19	Atypical factitious disorder with physical sympt

DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED

312.31	Pathological gambing
312 32	Kleptomania
312 33	Pyromania
312 34	Intermittent explosive disorder
312.35	Isolated explosive disorder
312.39	Atypical impulse control disorder

ADJUSTMENT DISORDER

309 00	with depressed mood
309.24	with anxious mood
309.28	with mixed emotional features
309.30	with disturbance of conduct
309.40	with mixed disturbance of emotions and conduct
309.23	with work (or academic) inhibition
309.83	with withdrawal
309.90	with atypical features

PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION

Specify physical condition on Axis III

316.00	Psychological factors affecting physical condition

PERSONALITY DISORDERS

Note: These are coded on Axis II

301 00	Paranoid
301.20	Schizoid
301.22	Schizotypal
301.50	Histrionic
301.81	Narcissistic
301.70	Antisocial
301.83	Borderline
301.82	Avoidant
301.60	Dependent
301.40	Compulsive
301.84	Passive-Aggressive
301 89	Atypical, mixed or other personality disorder

V CODES FOR CONDITIONS NOT ATTRIBUTABLE TO A MENTAL DISORDER THAT ARE A FOCUS OF ATTENTION OR TREATMENT

V65.20	Malingering
V62.89	Borderline intellectual functioning (V62.88)
V71.01	Adult antisocial behavior
V71.02	Childhood or adolescent antisocial behavior
V62.30	Academic problem
V62.20	Occupational problem
V62.82	Uncomplicated bereavement
V15.81	Noncompliance with medical treatment
V62.89	Phase of life problem or other life circumstance p
V61 10	Marital problem
V61.20	Parent-child problem
V61 80	Other specified family circumstances
V62.81	Other interpersonal problem

ADDITIONAL CODES

300 90	Unspecified mental disorder (nonpsychotic)
V71 09	No diagnosis or condition on Axis I
799 90	Diagnosis or condition deferred on Axis I
V71.09	No diagnosis on Axis II
799.90	Diagnosis deferred on Axis II

INSTRUCTIONS FOR DSM-III AXIS III: PHYSICAL DISORDERS

Axis III includes any current physical disorders or conditions relevant to the understanding or management of the individual. Such conditions are catalogued in the non-mental disorder sections of the International Classification of Diseases (ICD-9-CM). Physical conditions identified for an individual should be described in standard terms and will be coded later. Past disorders that are not currently active should be described in the Medical History but not listed in the diagnostic formulation.

UNIVERSITY OF PITTSBURGH
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

INITIAL EVALUATION FORM
CLINICAL SECTION
(5/14/82 Revision)

Name: ______________________
WPIC NUMBER ☐☐☐☐☐☐
Date: ______ m ______ d ______ y
Evaluation Setting: ______________________

DIAGNOSTIC SUMMARY

I. Clinical psychiatric syndromes *(Instructions and codes on back of pages 6 and 7)*

Main Formulation:	Codes	Alternatives to be ruled out	Codes
1.			
2.			
3.			
4.			

II Personality and specific developmental disorders *(Instructions and codes on back of pages 6 and 7)*

Main Formulation:	Codes	Alternatives to be ruled out:	Codes
1.			
2.			

III. Physical Disorders *(Instructions on back of page 7)*

Main Formulation:	Codes	Alternatives to be ruled out:	Codes
1.			
2.			
3.			
4.			

IV. Psychosocial stressors *(Instructions on back of this page)*

A. Ranked list:		Codes
	1.	
	2.	
	3.	
	4.	

B. Overall stressor severity:	1 None	2 Minimal	3 Mild	4 Moderate	5 Severe	6 Extreme	7 Catastrophic	0 Unspecified

V. Highest level of adaptive functioning during the past year *(Instructions on back of this page)*

1	2	3	4	5	6	7	0
Superior	Very Good	Good	Fair	Poor	Very Poor	Grossly Impaired	Unspecified

VI. Current functioning: *(Instructions on back of this page)*

	Superior	Adequate	Slightly Impaired	Moderately Impaired	Markedly Impaired	Unspecified
A. Occupational	1	2	3	4	5	0
B. With family	1	2	3	4	5	0
C. With other indiv. & groups	1	2	3	4	5	0

DISPOSITION

A. Admission or Referrals

Name of program or facility	Date of admission or appointment (month/day/year)	Release of information signed (✓)

Remarks: ______________________

B. Were referrals and recommendations accepted by patient/family? ☐ Yes ☐ No If no, explain ______________________

C. Legal status after evaluation:
☐ Voluntary (regular) ☐ Voluntary-302 Commitment discontinued ☐ 302 Commitment in force ☐ 303 Commitment ☐ 304 Commitment ☐ Other involuntary

---

EVALUATORS *(Who interviewed the patient)*

1. ______________________ Signature of first clinician ______ Code ______ Date

2. ______________________ Signature of second clinician ______ Code ______ Date

3. ______________________ Signature of third clinician ______ ______

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INSTRUCTIONS FOR DSM-III AXIS IV: PSYCHOSOCIAL STRESSORS

Axis IV assesses psychological stressors (both discrete events and ongoing strains) judged to be significant in the development or exacerbation of the present disorder

First identify relevant stressors during the past 12 months as specifically as possible and list them (up to 4) in order of importance To accomplish this ask for a summary of events and strains from the patient and then probe specifically to clarify the patient s initial report and to inquire about areas of the patient s life which may not have been mentioned spontaneously Situations which mainly reflect the patient s symptomology or dysfunctions should be excluded

Please consider the following categories of stressors

1 **Health:** e g acute or chronic physical illness or injury either to the patient or to someone close to the patient mental illness in significant others A physical disorder which is listed as such on Axis III can also be a psychosocial stressor if it creates a considerable strain on the patient s life
2 **Bereavement:** e g death of parent extended family member or significant other
3 **Love and marriage:** e g separation divorce persistent marital discord
4 **Parental:** e g pregnancy birth of a child loss of custody of child behavior problems in children
5 **Family stressors for children and adolescents:** e g cold or hostile relationship between parents cold or hostile parental behavior towards child stressful family situation
6 **Other familial relationships:** e g acute or chronic serious family arguments other than with immediate relative change in the frequency of family interaction
7 **Other relationships outside the family:** e g terminating a close friendship terminating organizational activities serious disruptions in social relationships
8 **Work:** e g demotion or promotion at work significant changes in work conditions having a difficult supervisor becoming retired lack of employment opportunities
9 **School:** e g began or changed a school or training program failed an important academic milestone completing or failing a school or training program
10 **Financial:** e g significant decrease in income took a large loan or mortgage foreclosure on a loan
11 **Legal:** e g court appearances major lawsuits arrests sentenced to (or served) a jail term
12 **Housing/environmental:** e g change in residence significant deterioration in living conditions eviction or threat of eviction
13 **Miscellanea:** e g being victim of a crime or assault facing a new culture

Next rate the severity (from 1 to 7) of the summed effect of all the psycosocial stressors listed This rating should be based on your assessment of the objective stress represented by the events or strains not on the patient s subjective vulnerability to the stressors The level of stress rated should he that likely to be experienced by an average person of similar socio-cultural circumstances as the patient and confronting the same events and strains The following examples may be used as a guide in making your ratings

Code	**Term**	**Adult examples**	**Child or adolescent examples**
1	None	No apparent psychosocial stressors	No apparent psychosocial stressors
2	Minimal	Minor violation of the law small bank loan	Vacation with family
3	Mild	Argument with neighbor change in work hours	Change in schoolteacher new school year
4	Moderate	New career death of close friend pregnancy	Chronic parental fighting change to new school illness of close relative birth of sibling
5	Severe	Serious illness in self or family major financial loss marital separation birth of child	Death of peer divorce of parents arrest hospitalization persistent and harsh parental discipline
6	Extreme	Death of close relative divorce	Death of parent or sibling repeated physical or sexual abuse
7	Catastrophic	Concentration camp experience devastating natural disaster	Multiple family deaths
0	Unspecified	No information or not applicable	No information or not applicable

In summing the effect of all stressors it may be necessary to take into account both the number and the severity of stressors For example one moderate stressor would receive a rating of 4 while a combination of 3 moderate stressors might receive a rating of 5 or 6 (the same rating which a single more severe stressor would receive)

INSTRUCTIONS FOR DSM-III AXIS V: HIGHEST LEVEL OF ADAPTIVE FUNCTIONING IN PAST YEAR

Axis V assesses an individual s highest level of adaptive occupational and social functioning (for at least a few months) during the past year

Recommended rating steps

1 Identify the best couple of months of adaptive functioning during the past 12 months and focus attention on that period for making the following assessments
2 Separately judge the individual s performance and degree of impairment in the following two regards
   a) Occupational Functioning This encompasses consistency and effectiveness of performance of expected role as worker student and or homemaker If an individual is unemployed not primarily because of inability to hold a job but because of navailability of employment his occupational assessment should focus on alternative roles e g homemaker
   b) Social Relations This encompasses frequency and quality of social interaction i e meeting communicating and sharing common activities with family members and with other individuals and groups
3 Combine the occupational functioning and social relations ratings using the scale below for obtaining the overall highest level of adaptive functioning in the past year As noted use of leisure time is considered only for the highest levels of functioning and essential self-care only for the poorest

Code	**Term**	**Description**
1	Superior	Unusually effective functioning in occupational functioning social relations and use of leisure time
2	Very Good	Better than average functioning in occupational functioning social relations and use of leisure time
3	Good	No more than slight impairment in either occupational or social functioning
4	Fair	Moderate impairment in either occupational functioning or social relations or some impairment in both
5	Poor	Marked impairment in either occupational functioning or social relations or moderate impairment in both
6	Very Poor	Marked impairment in both occupational functioning and social relations
7	Grossly Impaired	Gross impairment in virtually all areas of functioning including essential self-care
0	Unspecified	

INSTRUCTIONS FOR AXIS VI: CURRENT FUNCTIONING

Axis VI assesses current levels of functioning at work school or homemaking and relations with family and with other individuals or groups

Separately judge the individual s performance **during the past month** in the following three regards

a) Occupational Functioning This encompasses consistency and effectiveness of performance of expected role as worker student and or homemaker If an individual is unemployed not primarily because of inability to hold a job but because of inavailability of employment his occupational assessment should focus on alternative roles e g homemaker

b) Functioning with Family This encompasses frequency and quality of interaction with family members (i e meeting communicating and sharing common activities with them)

c) Functioning with Other Individuals and Groups This encompasses frequency and quality of interaction with non-family individuals and groups (i e meeting communicating and sharing common activities with them)

Determine the individual s current functioning level in each of these regards by using the scale given below

Code	**Functioning Level**	**Occupational Functioning**	**Functioning with Family and with Other Individuals and Groups**
1	Superior	Highly regular and competent work	Very frequent and close personal contacts
2	Adequate	Acceptable work regularity and competence	Acceptable frequency and closeness of personal contacts
3	Slightly Impaired	Occasionally misses work and or has some difficulty with competence	Rather restricted or irregular frequency and closeness of personal contacts
4	Moderately Impaired	Misses work frequently and or shows moderate incompetence	Infrequent and superficial or troubled personal contacts
5	Markedly Impaired	Works rarely or not at all and or is grossly incompetent	Almost non-existent or grossly disturbed personal contacts
0	Unspecified		

UNIVERSITY OF PITTSBURGH
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

INITIAL EVALUATION FORM
CLINICAL SECTION

Extra Page ______ a b c

Name: ______

WPIC NUMBER ☐☐☐☐☐

Date: ______ m ______ d ______ y

Evaluation Setting: ______

University of Pittsburgh
Medical Center

Western Psychiatric Institute & Clinic
3811 O'Hara Street, Pittsburgh, PA 15213-3241

PSYCHIATRIC EMERGENCY SERVICES

NAME
WPIC #

IMPRINT PLATE

DEMOGRAPHICS

Date: ____/_____/96 **Time:** (24hr) _____:_____, **Seq#:** _____

Demo: ______ yr old S M W D Sep White / Black / Hisp Other: ________ M F **Catchment** _____ **DEC Alert:** Y N / SCF / TxPlan

Legal: 201 / 30____ **Current Treatment:** Y N **Clinic:** Unknown or ____________________ **Active:** Y N

ICM/RC/Phone: ____________________ **Clinician/Phone:** ____________________

Psychiatrist/Phone: ____________________ **Primary MD/Phone:** ____________________

Insurance: Greenspring BC MA MC or ____________________ **PreCert Approved:** Y N **Searched:** Y N

Referred By/Organization: ____________________ **Scheduled:** Y N

TRIAGE

Reason for Evaluation: **Acuity:** Mild Priority Urgent

Vitals: Time: _____:_____ P: ______ BP: ____/______,______/_____ T: _____°C R: ______ **Breathalyzer:** ________ **Weight:** ______

Immediate Concerns:

- ☐ Danger to Self
- ☐ Danger to Others / Agitation
- ☐ Inability to Care for Self
- ☐ Psychosis or Disorientation
- ☐ Resistance to Evaluation
- ☐ Other:

Social Concerns

- ☐ DEC Treatment Plan
- ☐ Disposition Problem
- ☐ Legal Problem
- ☐ Indicators of Victimization
- ☐ CYS Involvement worker:

Medical Concerns:

- ☐ Drug/EtOH Use of: __________
- ☐ Possible Inoxication with: _____
- ☐ Withdrawl Indicators (last use quantity)
- ☐ Acute medical problem:
- ☐ Impaired Level of Consciousness

PSYCHIATRIC HISTORY

Sources of Information: *(mention reliability)*

Current Crisis *(Current treatment, Crisis duration & symptoms, Change in level of functioning - May include patient history)*:

Lethality: *(Danger to self or others)*

Other Pertinent Psychiatric History *(Previous hospitalizations, Age of onset)*

Substance Use: *(Last Use, Type of Substance, Quantity & Frequency)*

PSYCHIATRIC EMERGENCY SERVICES

Other History *(Past Psyc, Family Psyc, Social (Employment/Education/Home Environment), Personality, and Custody/Guardianship)*

Legal Charges ☐ **Physical/Sexual/Emotional Abuse** ☐ *(explain)*

Mental Status Examination *(Appearance, Behavior, Speech, Mood/Affect, Thought Form/Content, Perceptions, Cognition, Insight)*

Orientation: Person ☐ Place ☐ Time ☐ MMSE:

Primary Diagnosis:	**Axis:**	**DSM-IV Code:**	
Secondary Diagnoses	Axis	DSM-IV Code	Rule outs

Axis III: Medical Problems:	**Meds:** (include last dose taken, recent changes)
Non Allergic Drug Reactions:	
Allergies	

PES Services Given: *EKG / Physical Exam / Lab Test / Medication / Physical Supports / Other*

Axis IV: Psychosocial/Environmental Problems

Strengths

Axis V - Global Assessment of Functioning Score: Current Highest score in the past year

Assessment/Plan: Disposition **Appt Date/Time Unknown** __/__/__ @ __:__ **Priority:** Urgent Priority Routine

Reasons for Assignment to Level of Care

Patient's Social Supports:

InPatient Concerns: *Aggression/Self-Harm AMA Diet Elopement Falling Hypersexual IV Prostheses Substance Withdrawal Communication Impairment DNR Established Sensory Impairment Other*

Patient Left @ ___:___ ☐ Incomplete Evaluation **Discharge Legal Status:** 201 / 30__ **Reported to:**

Clinician ID # Name (Print)	Signature	Clinician ID # Name (Print)	Signature
Clinician ID # Name (Print)	Signature	Clinician ID # Name (Print)	Signature

PSYCHIATRIC EMERGENCY SERVICES

Symptom Inventory

- ☐ 01 Impaired Sensorium
- ☐ 02 Impaired Orientation and/or Memory
- ☐ 03 Poor Concentration Distractibility
- ☐ 04 Self Neglect
- ☐ 05 Bizarre Behavior
- ☐ 06 Self Abusive Behavior
- ☐ 07 Delusions
- ☐ 08 Hallucinations
- ☐ 09 Thought Process Disorganization
- ☐ 10 Elation, Expansiveness
- ☐ 11 Hyperactivity, Agitation
- ☐ 12 Psychomotor Retardation
- ☐ 13 Sleep Disturbance
- ☐ 14 Eating Disturbance
- ☐ 15 Sadness, Dysphoria
- ☐ 16 Suicidal Indicators
- ☐ 17 Anxiety
- ☐ 18 Phobias
- ☐ 19 Obsession/Compulsions
- ☐ 20 Somatization, Hypochondriasis
- ☐ 21 Dissociative Symptoms
- ☐ 22 Sexual Problems
- ☐ 23 Alcohol Abuse
- ☐ 24 Abuse of Other Drugs
- ☐ 25 Homicidality, Assaultiveness
- ☐ 26 Antisocial Behavior
- ☐ 27 Impulsivity
- ☐ 28 Social Withdrawal
- ☐ 29 Unstable, Dramatic Behavior
- ☐ 30 Overdependent, Hypersensitive Behavior
- ☐ 31 None of the above

Instructions *(All spaces are required to be completed; If left blank, it will be assumed the information was not asked)*

DEMOGRAPHIC - COMPLETED BY THE RECEPTIONIST (upon arrival of the patient)

Date: *Month/day/year*
Time: *Fill in time patient arrived in the DEC; use military time (e.g., 10:45 p.m. is 22:45)*
Seq #: *Indicates patient sequence of arrival to the DEC, in relation to other patients)*
Demo: *Implies the following information is basic demographic information of the identified patient)*
____ yr (year) old - *Fill in age of patient*
Circle one: S (single) M (married) W (widow/widower) D (divorced) Sep (separated)
Circle one: White / Black / Hisp (hispanic)/Other: *(identify race on this line)*
Circle one: M (male) F (female)
Catchment: *Patient's base service unit area,(ie. 9-C1 for WPIC); identified by their current address*
DEC Alert: *Circle one:* Y N / SCF(special concern file) / TxPlan (treatment plan)
Legal: *Specify arrival legal status: 201/30__ (circle and/or complete with 302, 303, 304, 304C, etc.)*
Current Treatment: *Circle one:* Y N *(No implies patient is not in current outpatient treatment)*
Clinic: Unknown or (If known specify Clinic/Phone:
Active: *Circle one:* Y N *(N indicates No current outpatient treatment is active)*
ICM/RC/Phone: Circle ICM (Intensive Case Manager) or RC (Resource coordinator), to identify if the patient has either. *Identify name of ICM/RC and phone number if known, otherwise write "unknown"*
Clinician/Phone: *If in current treatment, identify name of clinician and phone number if known, otherwise write "unknown"*
Psychiatrist/Phone: *If in current treatment, identify name of Psychiatrist and phone number if known, otherwise write "unknown"*
Primary MD/Phone: *If in current treatment, identify name of Primary MD and phone number if known, otherwise write "unknown"*
Insurance: *Circle one:* Greenspring/MA (medical assistance) /BC (blue cross) / MC (medicare) or *(fill in insurance name)*
PreCert: (PreCertification) Approved: *Circle one:* Y N *(Yes or No)*
Searched: *Circle one:* Y N *(Yes or No) indicates whether or not initial Safety Search was completed*
Referred by/Organization: *Fill in the blank of name of referral; if patient referred themselves, indicate"self")*
Scheduled: *Circle one:* Y N *(Yes or No) indicates whether or not patient's visit to the DEC was scheduled*

TRIAGE - COMPLETED BY THE TRIAGE CLINICIAN

Reason for Evaluation: *Identify WHY the patient is currently seeking treatment/what is the crisis*
Acuity: *Circle one:* Mild/Priority/Urgent *(scale used in the DEC to determine acuity level of patient)*
Vitals: Time: *Write military time vital signs were completed in triage*
Breathalyzer: Write in percentage; indicate if not necessary
Weight: *(necessary on all inpatients otherwise, on an as needed basis)*
Immediate Concerns/Social Concerns/Medical Concerns: *Place a check or'x' in the appropriate boxes based on triage evaluation*

PSYCHIATRIC HISTORY - COMPLETED BY THE CLINICIAN/MD

Sources of Information: *Name all sources including WPIC records, etc*
Current Crisis: "WHAT BROUGHT THE PT TO THE ER, TODAY!"
Lethality: *Address use of firearms.*
Pertinent Psychiatric History: *Expand on relevant history*
Substance Use: *Specify type, quantity, frequency of each substance; specify last use: date/time*
Other History: *Discuss past psychiatric history, family psychiatric history, social history (employment, education, home environment), personality/characterological traits, and custody/guardianship concerns.*
Legal Charges *(current)*, **Physical/Sexual/Emotional Abuse:** *Identify physical/sexual/elder/domestic/spousal/psychological abuse*
Mental Status Examination: *Record detailed description of identified patient*
Orientation: *Check all boxes that apply* **MMSE** (Mini Mental Status Exam) *Write the total points/total possible Note problem areas for patient.*
Primary Diagnosis: *Specify DSM-IV Axis and Code.*
Secondary Diagnoses: *Specify all other DSM-IV diagnoses and codes (for Axis I and II)*
Rule Outs: *Specify rule out DSM-IV diagnoses and codes (for Axis I and II)*
AXIS III: Medical Problems: *Specify all current medical problems (no coding is required)*
Meds: *List for current medications: name, route, time, dose (mg), last dose, and recent changes. List known allergies, non allergic drug reactio*
Axis IV: *List psychosocial/environmental problems (i.e. divorce, death, homelessness, etc.) List strengths also*
Assessment: Summarize findings from current evaluation. Note the Appt *(appointment)* Date/Time *or circle "unknown".*
Priority: Circle Urgent (within 24 hours), Priority (within 72 hours) Routine (per clinic schedule) *to indentify scheduling time frame*
Inpatient Concerns: *Circle all that apply to alert inpatient unit of potential issues or problems*
Patient Left @: *Identify military time patient left the evaluation center or check incomplete evaluation*
Reported to: *Identify the inpatient staff taking the admission report or the outpatient intake worker collecting the information*
Symptom Inventory Checklist: *Check all that apply for current evaluation*

In order to comply with the Child Protective Service Law (Act 33), applicants who are residents of Pennsylvania and are applying for positions providing child care services must submit with their application copies of the following obtained within the preceding year:

1. A report of criminal history record information from the Pennsylvania State Police stating that the central repository contains no such information relating to the applicant (form attached)
2. Certification from the Department of Public Welfare as to whether the applicant is a perpetrator of a founded or indicated report of child abuse (form attached)

Non-residents of Pennsylvania must submit a copy of a report of federal criminal history record information from the Federal Bureau of Investigation with their employment application.

Applicants are required to provide the original document (s) prior to employment. No offer of employment is valid without the above information. Please forward a copy of the original document (s) to:

PERSONNEL DEPARTMENT
WESTERN PSYCHIATRIC INSTITUTE
AND CLINIC
3811 O' Hara Street
Pittsburgh, PA 15213

INSTRUCTIONS FOR THE COMPLETION OF THE PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

The Child Protective Services Law requires that the child abuse history of applicants to child care programs be verified within 30 days from the date of hire. The clearance is also required for persons wishing to be foster or adoptive parents. In addition, individuals may request voluntary certification which indicates the status of child abuse history and criminal history.

To request the clearance, the applicant must complete, in ink, Section I only of the attached "Pennsylvania Child Abuse History Clearance" and submit it to the Department of Public Welfare with a $10.00 check or money order. Cash will not be accepted. **Incomplete or illegible applications will be returned unprocessed.**

Another form must be completed for Criminal History Clearance through the Pennsylvania State Police. Out-of-state residents must also obtain clearance through the FBI files. You may write or call ChildLine (717-783-6211) for all of the necessary forms.

Please refer to the information below when completing the application or when reviewing the Department's response. Please type or print except where signature is required. The completed clearance is valid for one year for employment, adoption, foster care, or CWEP purposes. A Voluntary Certification is valid for two years.

SECTION I - APPLICANT IDENTIFICATION (To be completed by applicant)

Check one box which best describes the reason for requesting the clearance:

- **EMPLOYMENT** - Check block #1 if you need the clearance as a candidate for child care program employment/operation.
- **ADOPTION** - Check block #2 if you need the clearance for purposes of adopting a child who is a non-relative. The clearance is not required if you are adopting a child who is already related to you, by birth or marriage.
- **FOSTER CARE** - Check block #3 if you need the clearance in order to be approved as a foster parent.
- **VOLUNTARY** - Check block #4 if you need a voluntary clearance as a participant in a service such as a Big Brothers/Big Sisters program. You must include a copy of the "Request For Criminal History Record Information" obtained from the Pennsylvania State Police. Out-of-state residents must also include a copy of their FBI clearance.
- **CWEP** - Check block #5 if you are a Community Work Experience Program participant who will be assigned to a child care program. An official of your County Assistance Office must sign the application. **No fee is required.**

RETURN ADDRESS BLOCK

- Print your full legal name (first, middle, last, do not use initials) and your entire current address. Your P.O. Box No., Apt. No., and Zip Code must be included.

SOCIAL SECURITY NUMBER

- Enter your complete social security number. The disclosure or your Social Security Number is voluntarily sought to verify your identity pursuant to the authority of the Child Protective Services Law, 11 P.S. § 2214 (i).

AGE AND DATE OF BIRTH

- Enter your current age and exact date of birth.

SEX

- Check the appropriate block.

COUNTY OF CURRENT RESIDENCE

- Enter the name of the county where you currently live.

LENGTH OF TIME AT CURRENT ADDRESS

- Enter the number of years and months you have resided at your current address.

DAYTIME TELEPHONE NO.

- Enter the telephone number where you can be reached between 8:00 a.m. and 4:00 p.m. Include area code.

OTHER NAMES USED BY APPLICANT SINCE 1975

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- Enter all other names you have used since 1975. Include maiden name, nicknames, and aliases.

FORMER ADDRESSES

- List all former addresses where you lived or received mail since November 1975.
- List the most recent address first. Do not include current address.
- Include approximate dates you resided at each address.
- Use a second page if necessary.

MEMBERS OF APPLICANT'S HOUSEHOLD

- Enter the full name (no initials please), relationship to you, age, and sex of all persons who live with you at your current address or who have lived with you at any of your former addresses.
- Use a second page if necessary.

APPLICANT'S SIGNATURE AND DATE

- Read the sentence preceding the signature line.
- Sign and date the application. The application must contain your original signature; copies are unacceptable. Your application will be returned unprocessed if signed by anyone other than the applicant.
- Detach instructions and mail the completed application along with a $10.00 check or money order payable to the "Department of Public Welfare." Do not send cash. Mail to:

Department of Public Welfare
P.O. Box 8170
Harrisburg, PA 17105-8170

SPECIAL NOTES	
DUE TO THE NATURE AND CONFIDENTIALITY OF THE INFORMATION REQUESTED, CHILD ABUSE CLEARANCES MUST BE RETURNED DIRECTLY TO THE APPLICANT. BEFORE MAILING YOUR APPLICATION TO THE DEPARTMENT OF PUBLIC WELFARE, PLEASE MAKE ONE COPY AND GIVE TO YOUR EMPLOYER IF YOU ARE BEING HIRED ON A PROVISIONAL BASIS.	YOUR ORIGINAL PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE WILL BE RETURNED TO YOU WITH AN OFFICIAL SIGNATURE IN SECTION II. HAVE A COPY OF THE CLEARANCE MADE AND GIVE THE COPY TO THE AGENCY TO RETAIN IN ITS FILE. THE AGENCY MUST ALSO VIEW THE ORIGINAL BUT THE APPLICANT RETAINS THE ORIGINAL.

SECTION II - RESULTS OF HISTORY CHECK (To be completed by ChildLine Staff Only)

The appropriate block will be checked by ChildLine staff stating whether the applicant's name is contained in the Statewide Central Register as a perpetrator of child abuse.

REPORTS IDENTIFIED

- The status (Founded or Indicated) and date of incident of all reports will be entered.
- Founded means that a court has determined that a child was abused.
- Indicated means that the Child Protective Services Agency has determined that a child was abused.

VERIFIER'S SIGNATURE AND DATE

- The Department employee who performed the history clearance will sign and date the form at the time of its completion.

SUPERVISOR'S SIGNATURE AND DATE

- When an applicant's name is located in the Statewide Central Register, a supervisor will confirm the information and sign the form.

SECTION III - VOLUNTARY CERTIFICATION (To be completed by ChildLine Staff Only)

The following section will be completed by ChildLine Staff for those applicants who request voluntary certification and have submitted a copy of the clearance(s) obtained from the Pennsylvania State Police and the FBI (out-of-state residents only).

Although child abuse and/or criminal convictions may prohibit hire into a child care position pursuant to the Child Protective Services Law (11. P.S. 2223.1(e)), it is the decision of the parent or guardian who reviews this information to determine whether to use the services of the applicant.

VERIFIER'S SIGNATURE AND DATE

- The Department employee who performed the history clearance will sign and date the form at the time of completion.

SUPERVISOR'S SIGNATURE AND DATE

- When an applicant's name is located in either of the three files, a supervisor will confirm the information and sign the form.

PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

INSTRUCTIONS: Complete Section I only. Please print clearly in ink. Enclose check or money order for $10.00 payable to Department of Public Welfare. **DO NOT SEND CASH.** Applications received without fee will not be processed. Send to Department of Public Welfare, P.O. Box 8170, Harrisburg, PA 17105-8170

SECTION I - APPLICANT IDENTIFICATION

(Indicate Reason For Requesting Clearance (Check ONE Block Only)

☐ EMPLOYMENT	4. ☐ VOLUNTARY A copy of your Request for Criminal History Record Information (Form SP4-164) must be attached. Out-of-State residents must also attach a copy of their FBI Clearance (Form FD-258).
2. ☐ ADOPTION	5. ☐ CWEP (Community Work Experience Program Participant)
3. ☐ FOSTER CARE	Signature of Confirming CAO Representative ______ CAO Telephone No. ______

CHILDLINE USE ONLY

DATE RECEIVED BY CHILDLINE

RETURN ADDRESS BLOCK - PLEASE PRINT CLEARLY

NAME

STREET

APT. NO. BOX NO.

CITY, STATE

ZIP CODE

IN THE BLOCK ABOVE, ENTER FULL NAME OF APPLICANT. DO NOT USE INITIALS. ALSO ENTER ENTIRE CURRENT ADDRESS.

SOCIAL SECURITY NO. ▶ — —	
AGE	DATE OF BIRTH
SEX ☐ M ☐ F	COUNTY OF CURRENT RESIDENCE
LENGTH OF TIME AT CURRENT ADDRESS ▶ ______ YRS. ______ MOS.	
DAYTIME TELEPHONE NO. ▶ ( )	

OTHER NAMES USED BY APPLICANT SINCE 1975 (Include Maiden Name, Nicknames, Aliases) (First, Middle, Last)	
1.	2.

FORMER ADDRESSES OF APPLICANT (from November 1975 up to, but not including, current address) Include approximate dates you resided at each address. List Street, Apt. No., Box No., City, State, County, & Zip Code. For military service list City, State, and/or Country where stationed. Attach additional pages if necessary.

1.	______ TO ______ MO/YR MO/YR	3.	______ TO ______ MO/YR MO/YR
	______ TO ______ MO/YR MO/YR	4.	______ TO ______ MO/YR MO/YR

MEMBERS OF APPLICANT'S HOUSEHOLD (Include all persons who currently reside with you or who have resided with you at any of your former addresses.) Attach additional pages if necessary.

NAME (First, Middle, Last, do not use initials)	RELATIONSHIP TO APPLICANT	AGE	SEX
1.			
2.			
3.			
4.			
5.			
6.			

I certify that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code).

Applicant's Signature ______ Date ______

SECTION II - RESULTS OF HISTORY CHECK - Childline Use Only

☐ APPLICANT **IS NOT** LISTED IN THE STATEWIDE CENTRAL REGISTER AS A PERPETRATOR OF CHILD ABUSE.

☐ APPLICANT **IS** LISTED IN THE STATEWIDE CENTRAL REGISTER AS A PERPETRATOR OF CHILD ABUSE. (SEE BELOW.)

REPORTS IDENTIFIED

	STATUS	DATE OF INCIDENT		STATUS	DATE OF INCIDENT
1.			3.		
2.			4.		

BEST COPY AVAILABLE

1371

VERIFIER ______ DATE ______ VERIFIER'S SUPERVISOR ______ DATE ______

01143A

APPLICATION

CY 113 - 12/88

SPECIAL NOTES

DUE TO THE NATURE AND CONFIDENTIALITY OF THE INFORMATION REQUESTED, CHILD ABUSE CLEARANCES MUST BE RETURNED DIRECTLY TO THE APPLICANT.

BEFORE MAILING YOUR APPLICATION TO THE DEPARTMENT OF PUBLIC WELFARE, PLEASE MAKE ONE COPY AND GIVE TO YOUR EMPLOYER IF YOU ARE BEING HIRED ON A PROVISIONAL BASIS.

YOUR ORIGINAL PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE WILL BE RETURNED TO YOU WITH AN OFFICIAL SIGNATURE IN SECTION II. HAVE A COPY OF THE CLEARANCE MADE AN GIVE THE COPY TO THE AGENCY TO RETAIN I ITS FILE. THE AGENCY MUST ALSO VIEW THE ORIGINAL BUT THE APPLICANT RETAINS THE ORIGINAL.

SECTION III - VOLUNTARY CERTIFICATION - Childline Use Only

________________________________ has requested a certification which includes a clearance of his/her name against the child abuse and criminal history files.

The results of the child abuse history clearance are listed in Section II on the reverse side. The results of the criminal history clearance(s) is (are) listed below. Out-of-state residents must have criminal history clearance from both the Pennsylvania State Police and the FBI. The voluntary certification may be obtained every two years.

It is the responsibility of parents and guardians to review this information to determine the suitability of the applicant as a substitute caregiver.

PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

- ☐ Applicant is named as the perpetrator of a "Founded" child abuse report which occurred in the last five years.
- ☐ Applicant is named as the perpetrator of a "Founded" child abuse report which occurred over five years ago.
- ☐ Applicant is named as the perpetrator of an "Indicated" child abuse report.
- ☐ Applicant is not named as the perpetrator of any child abuse reports contained in the Statewide Central Register.

PENNSYLVANIA STATE POLICE CLEARANCE

- ☐ Record exists and contains convictions which prohibit hire in a child care position. Report attached.
- ☐ Record exists, but convictions do not prohibit hire in a child care position. Report attached.
- ☐ Record exists, but convictions are beyond the five year limit and do not prohibit hire in a child care position. Report attached.
- ☐ No record exists. Report attached.

FBI CLEARANCE

- ☐ Record exists and contains convictions which prohibit hire in a child care position. Report attached.
- ☐ Record exists, but convictions do not prohibit hire in a child care position. Report attached.
- ☐ Record exists, but convictions are beyond the five year limit and do not prohibit hire in a child care position. Report attached.
- ☐ Record exists, but no convictions are shown. This does not prohibit hire in a child care position.
- ☐ No record exists. Report attached.

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VERIFIER	DATE	VERIFIER'S SUPERVISOR	DATE

SP 4-164 (3-91)

PENNSYLVANIA STATE POLICE

REQUEST FOR CRIMINAL RECORD CHECK

TYPE OR PRINT LEGIBLY WITH INK

FOR CENTRAL REPOSITORY USE ONLY (LEAVE BLANK)

PART I TO BE COMPLETED BY REQUESTER

DATE OF REQUEST

NAME (SUBJECT OF RECORD CHECK) (Last) (First) (Middle)

MAIDEN NAME AND/OR ALIASES	SOCIAL SECURITY NO. (SOC)	DATE OF BIRTH (DOB)	SEX	RACE

(FOLD)

REASON FOR REQUEST: (CHECK APPROPRIATE BLOCK)

☐ EMPLOYMENT

☐ OTHER (SPECIFY) ______________________

☐ INDIVIDUAL ACCESS AND REVIEW BY SUBJECT OF RECORD CHECK OR LEGAL REPRESENTATIVE (AFFIDAVIT OF LEGAL REPRESENTATION ATTACHED)

REQUESTER IDENTIFICATION: (CHECK APPROPRIATE BLOCK)

☐ INDIVIDUAL/NONCRIMINAL JUSTICE AGENCY - ENCLOSE A CERTIFIED CHECK/MONEY ORDER (NONREFUNDABLE) IN THE AMOUNT OF $10.00 PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA".
DO NOT SEND CASH/PERSONAL CHECK.

☐ NONCRIMINAL JUSTICE AGENCY - FEE EXEMPT

INFORMATION WILL BE MAILED TO REQUESTER ONLY

NAME OF REQUESTER

ADDRESS

CITY STATE ZIP CODE

LIST TELEPHONE NUMBER TO BE USED TO CONTACT REQUESTER IF NECESSARY.

(AREA CODE)

☐☐☐ - ☐☐☐ - ☐☐☐☐

NOTE

A "NO RECORD" RESPONSE WILL TAKE TWO (2) WEEKS TO PROCESS; A "RECORD" RESPONSE WILL TAKE LONGER

IF THIS FORM IS NOT LEGIBLE OR PROPERLY COMPLETED, IT WILL BE RETURNED UNPROCESSED TO REQUESTER.

(FOLD)

REQUESTER CHECKLIST

✓ DID YOU ENTER THE FULL NAME, DOB, AND SOC?

✓ DID YOU ENCLOSE THE $10.00 FEE (CERTIFIED CHECK/MONEY ORDER)? DO NOT SEND CASH/PERSONAL CHECK.

✓ DID YOU ENTER YOUR COMPLETE ADDRESS INCLUDING ZIP CODE AND TELEPHONE NUMBER IN THE BLOCKS PROVIDED?

AFTER COMPLETION MAIL BOTH COPIES WITH CARBON INTACT TO

PENNSYLVANIA STATE POLICE CENTRAL REPOSITORY
1800 ELMERTON AVENUE
HARRISBURG, PENNSYLVANIA 17110-9758

PART II CENTRAL REPOSITORY RESPONSE

INFORMATION DISSEMINATED:

☐ NO RECORD ☐ CRIMINAL RECORD ATTACHED

INQUIRY/DISSEMINATED BY:

SID NO.:

THE INFORMATION DISSEMINATED BY THE CENTRAL REPOSITORY IS BASED SOLELY ON THE FOLLOWING IDENTIFIERS THAT MATCH THOSE FURNISHED BY THE REQUESTER

☐ NAME ☐ DATE OF BIRTH ☐ RACE

☐ SOC ☐ MAIDEN/ALIAS NAME ☐ SEX

CERTIFIED BY:

(DIRECTOR, CENTRAL REPOSITORY)

Response based on comparison of data provided by the requester in Part I against information contained in the files of the Pennsylvania State Police Central Repository only, and does not preclude the existence of other criminal records which may be contained in the repositories of other local, state or federal criminal justice agencies

MENTAL STATUS EXAM

From Trzepacz, P.T & Baker, R.W. (1993) The Psychiatric Mental Status Examination. New York: Oxford University Press

APPEARANCE, ATTITUDE & ACTIVITY

Appearance: Appearance, sounds, odors

Level of consciousness: overall arousal, alertness, responsiveness, (hypervigilance, anxiously attentive, easily startled) or subnormally alert (drowsy, lethargic, clouding of consciousness or a degree of diminished alertness) comatose or vegetative. fluctuating levels of consciousness by history, degree of distractibility, internal preoccupation

Age: to what extent does patient appear stated age

Position & Posture: slouching, rigidly erect, nonverbal cues to mood

Attire & Grooming: (context dependent) hygiene, clothing, make-up, bizarre haircut, discoloration of fingers, teeth. (unkempt, disheveled, neatly dressed)

Eye contact: (culture dependent) degree, staring or avoiding

Physical characteristics: tattoos, needle marks, skin lesions, obvious abnormalities, handicaps, usual demographic descriptors

Facial expression: sad, happy, angry, bored. surprised, confused, anxious, pained

Attitude: general demeanor (cooperative, uncooperative, hostile, guarded, suspicious, regressed) degrees of politeness & assertiveness, degree of inhibitedness, vigilance, resistance, manipulativeness, degree of splitting (vacillation between idealization and devaluation),

Activity: movement (hyperactivity to bradykinesia, pareisis or paralysis), accessory movements (arm-swing, gestures), gait, tremors, restlessness, agitation, bizarre motions (athetoid, choreiform movements, tardive dyskinesia, tics), automatic movements (chewing, lip smacking, picking at clothes), mannerisms (compulsions),posturing, grimacing, gesturing, perseverations,

MOOD & AFFECT

Mood: predominant emotional state, patient's self report & non-verbal behaviors.

typical or atypical, intensity of feeling
changeability of mood states
euthymic=normal, consistent, calm, appropriate
dysphoric=down, sad, despondent, remoreseful,
euphoric= cheerful, ecstatic, elatic, happy
angry, apathetic, apprehensive

Affect: moment-to-moment mood changes, external expression of feelings, behaviors (smiling, frowning, joking, crying). may be concordant with mood or different

Parameters: Approriateness & congruence with mood
Intensity: normal, blunted, exaggerated, flat, dramatic
Mobility: mobile, fixed, constricted, labile
Range: full or restricted
Reactivity: reactive & responsive or dulled

SPEECH & LANGUAGE

Fluency: initiation and flow of language, aphasias

Prosody of speech: rate, rhythm, and stress (musicality, intonation, phrasing, pressure of speech)

Quality of speech: loudness (yelling, soft-spoken, whispering)
pitch & intonation
amount (sparse to talkative)
spontaneity
articulation (pronunciation, slurring)
dialect
comprehension
stuttering, rhyming, word salad, repitition,rhyming, alliteration

THOUGHT PROCESS, THOUGHT CONTENT & PERCEPTION

Thought Process: inferred from communication or questions, based on whole presentation. Is conversation direct & informative or vague & confused? Is speech spontaneous, flow of ideas smooth?

- Disordered connectedness and organization of thought
  - circumstantiality, loose associations
  - flight of ideas, word salad, tangengtiality
- Other peculiarities of thought process
  - clang associations, echolalia, thought blocking
  - neologisms, perseveration

Thought Content: especially opening comment and during unstructured time. open-ended questions and specific disturbances. patient may or may not be aware of abnormalities.

Delusions=objectively incorrect beliefs, from bizarre to plausible, evaluate in socio-cultural context, corroborate with family member.

- Content: paranoid (persecutory & grandiose), somatic, erotomanic, referential, nihilistic, delusional denial, Schneiderian (external control: thought broadcasting, insertion & insertion--common in Schizophrenia)
- Organization & Consistency: stable, systematized or not
- Emotional & Behavioral Impact

Near-Delusional Beliefs: overvalued ideas, magical thinking
Obsessions & Preoccupations: ruminative, doubting, inhibiting,
Phobias
Violent Ideations (suicidal or homicidal)

Perception: hallucinations (auditory, visual, olefactory, gustatory)
illusions, derealizations, depersonalization, autoscopy, deja vu jamais vu

COGNITION

Orientation: person, place & time (Folstein) - Neurological screening
Attention & Concentration: visual, auditory & verbal
Memory: immediate recall, short term, long term (proceducal & declarative, recent & remote, episodic & semantic), amnesias, pseudodementia
Constructional Ability & Visuospatial Functon
Abstraction & Conceptualization: ability to analyze information, categorize, compare, hypothesize, & reason (inductive & deductive thinking), abstract thinking, humor

INSIGHT & JUDGMENT (handout: Cog. Domains & Representative NΨ tests); ask few ?s to [illegible]

Insight: awareness & understanding of feelings, thoughts, & reactions; of how one's personality & behaviors contribute to symptoms, problems, etc. Adequate or impaired : level of denial, externalization of blame, not taking responsibility.

Judgment: weighing & comparing different aspects of an issue. situation dependent. process that precedes outcome (decision or action). ask simple hypothetical questions. affected by defense mechanisms

The Mini-Mental State Examination

Name______________________________ **Date**__________________

Orientation:

		Score	
1. What is the...	Year?	0	1
	Season?	0	1
	Date?	0	1
	Day?	0	1
	Month?	0	1
2. Where are we...	State?	0	1
	County?	0	1
	Town or City?	0	1
	Hospital?	0	1
	Floor?	0	1

Registration:

3. Name three objects, taking one second to say each. Then ask the patient all three after you have said them.
Table-Forest-Dog
Repeat the answers until the patient repeats all three. 0 1 2 3

Attention and Calculation:

4. Serial sevens. Give one point for each correct answer. Stop after five answers. Alternate: spell **WORLD** backwards. 0 1 2 3 4 5

Recall:

5. Ask for names of three objects learned in Question 3. Give one point for each correct answer. 0 1 2 3

Language:

6. Point to a pencil and a watch. Have the patient name them as you point. 0 1 2

7. Have the patient repeat "No ifs, ands or buts." 0 1

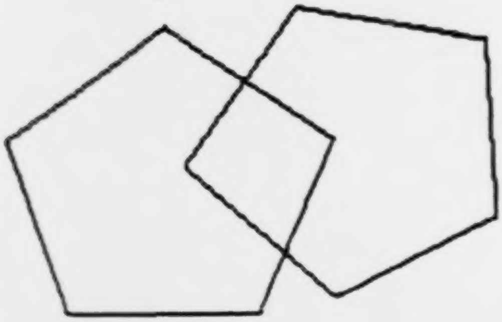
8. Have the patient follow a three stage command: "Take the paper in your right hand. Fold the paper in half. Put the paper on the floor." 0 1 2 3

9. Have the patient read and obey the following: "Close your eyes." (Write in large letters). 0 1

10. Have the patient write a sentence of his or her own choice. (The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring.) 0 1

11. Enlarge the design below and have the patient copy it. (Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle.) 0 1

Maximum Score = 30



Close your eyes.

Sentence:

Drawing:

ASSESSMENT AND COUNSELING

TREATMENT PLANNING MANUAL

TREATMENT PLAN

Policy and Procedures

I. POLICY

To assure high quality care, each patient being treated at WPIC shall have a written comprehensive treatment plan recorded in the patient's clinical record which is set forth in language that is understandable to the patient as well as the treating staff. The treatment plan serves not only to document patient care in the clinical record but also as a basis for patient education and as a communication vehicle among staff. At WPIC, responsibility for continuity of care shall reside in the outpatient setting while inpatient services shall represent the acute, intensive, and brief portion of the patient's treatment. The following clinical administrative policies pertain in order to assure continuity of care in the development and implementation of the treatment plan.

1. The treatment planning process utilizes the data from a comprehensive assessment.

2. Each catchment area patient shall have an outpatient clinician in an outpatient program designated as primarily responsible and accountable for the patient's treatment program. In addition to the provision of direct services, this clinician shall be responsible for the coordination of other services required for the patient and the collaboration of service providers working with the patient.

3. The outpatient treatment plan is developed by the primary clinician in collaboration with the attending physician.

4. Patients who require hospitalization during the course of outpatient treatment shall continue to be followed by their primary outpatient clinician who will collaborate with inpatient staff with specific reference to disposition and plans for follow-up care. It is assumed that the patient will return to the outpatient care of this primary clinician to the extent possible.

5. The inpatient treatment plan is developed collaboratively by the multidisciplinary treatment team during the regularly occurring multidisciplinary treatment team meetings.

6. The inpatient treatment plan is developed to address those problems which necessitated the inpatient hospitalization and whose resolution will result in discharge from the inpatient setting. While the patient may experience problems in addition to those precipitating hospitalization, it may not be feasible to address these in an acute care setting.

7. The Nursing Care Plan, based upon the nursing assessment and reflecting current standards of nursing practice will be documented as part of the overall inpatient treatment planning process. Nursing interventions, related to established goals which are based upon the patient needs, problems, capabilities and limitations, will document measures that: (1) facilitate prescribed medical/psychiatric care; (2) relate to other physiological, psychosocial and environmental factors; and (3) deal with patient/family education and patient discharge planning.

8. a. Responsibility for written documentation of the Inpatient Treatment Plan shall lie with the respective multidisciplinary team members. In general, written formulation of Problems A and B will reside with the Primary Nurse.

b. In the case of the John Merck Unit, B Problems will also be recorded by Developmental Specialists.

c. Documentation of Problem C will be the responsibility of the Physician's Assistant, Nurse Practitioner or Resident Physician. In the case of any medical problem which requires nursing interventions, the primary nurse shall be responsible for documenting interventions under the Nursing Interventions section of the treatment plan. Any particular primary nurse, in conjunction with the treatment team, may elect to take responsibility for the actual documentation of the Category C (Medical) Problems.

d. Written documentation of Problem D will reside with the individual patient's social worker. Included in D Problems will be issues of disposition planning.

e. Documentation of Category E Problems may reside with any member of the professional staff and may include problems in the areas of patient/family education and social and occupational functioning. (1) Developmental Specialists will be responsible for documentation of psychoeducational activities under the E Problem Category on Child and Adolescent Services. (2) Documentation involving activities conducted by Creative and Expressive Arts Therapists, Recreational Therapists, and Milieu Therapists will be found under the Methods section of the treatment plan. The actual written documentation of these activities will be determined by the individual inpatient unit leadership group.

9. Patients admitted to inpatient units who do not have a designated primary outpatient clinician shall have by necessity a treatment plan focused only on the brief period of inpatient hospitalization. Arrangements for follow-up will be the responsibility of the inpatient social worker.

10. The patient shall actively participate in the development and revisions of his/her treatment plan and will sign the treatment plan form when possible. Individual patients or family members, in the case of children, may be provided with a copy of the treatment plan as appropriate.

II. PROCEDURES

A. Definition and Formulations of Problems

1. Problem areas have been chosen which correspond to the DSM-III-R diagnostic classification system.

AXIS I	- Clinical Syndromes	A.	Problems/Needs related to Axis I Diagnosis
AXIS II	- Developmental Disorders and Personality Disorders	B.	Problems/Needs related to Developmental/Personality Disorder (Axis II) Diagnosis

AXIS III	- Physical Disorders and Conditions	C.	Physical/Medical Problems
AXIS IV	- Severity of Psychosocial Stressors	D.	Family/Social Network; Environmental (Housing, employment, educational, cultural, legal) Problems; nature of stressor is acute (e.g. death in the family) or chronic (e.g. child exposed to persistent parental fighting).
AXIS V	- Global Assessment of Functioning	E.	Impairment in Adaptive Functioning: Problems/needs in relation to disability and impairment in the performance of occupational and social roles (e.g. inability to hold a job, difficulty relating to spouse, child rearing problems); nature of impairment is chronic.

2. Problems are formulated in terms of:

   a. Symptoms of a definable diagnostic category or symptoms/deficits, etc. which can be formulated as part of a differential diagnosis.

   b. Need for further evaluation or assessment.

   c. Medical Syndromes/symptoms of a definable diagnostic category, or deficit, which can be formulated as part of a differential diagnosis, described in layman's language when possible.

   d. Areas of need in terms of environmental and/or social network support systems.

   e. Patient assets which are under-utilized or interfered with.

3. Problem statements are generally clustered around the diagnostic formulation. That is, symptoms of depression are presented as a single problem. This principle of clustering also holds true for symptoms/behaviors which are characteristic of other psychiatric diagnoses as well.

4. While problems are designated by date of formulation, category, and problem number, this does not imply a prioritization of problems by importance.

B. Strengths: Definition and Documentation

1. Patient strengths and assets may include factors corresponding to the various domains of the multiaxial diagnostic formulation. It is not necessary to list strengths to reflect each AXIS. Examples are provided to illustrate how one might elicit strengths and assets.

AXIS I - insight into illness; understands the need for treatment

AXIS II - above average intelligence; ability to establish personal relationships

AXIS III - Physical stamina

AXIS IV - Stable family supports; job to return to

AXIS V - interpersonal skills; good work history

2. Patient strengths/assets are documented at the beginning of each treatment plan in the space provided. They are to be recorded on page one only of a multi-page treatment plan.

C. Definition and Formulation of Goals

1. Goals, for the purposes of treatment plans, are to be equated with the concept "Long Term Goals." Short term goals, in like manner, are the equivalent of performance statements or measurable objectives. Thus both goals and performance statements must be documented on the treatment plan for the designated problem area or problem/symptom cluster.

2. Long term goals are statements of attainable outcome which are directly related to the resolution of problems cited. There should be a goal statement for each problem. Goals are to be written with the patient's agreement in mind. Goal statements are abstractions whose measurement, quantification, and attainment need to be defined through the specification of short term goals.

3. Short term goals are the performance criteria to be utilized in the measurement of long term goals. They include: (a) patient behaviors which demonstrate movement toward a particular goal; and (b) specific activities which when accomplished by a patient give evidence that the goal has been attained. These performance criteria are usually directly observable behaviors or behaviors about whose presence or absence one can make a direct inference.

D. Methods

Methods answer the question, "How will intervention be carried out to achieve the stated goals?" This involves specifying:

1. Intervention procedures to be utilized (e.g. individual or group therapy, medication, role-playing, diagnostic procedures, checklists, contracts, referrals);

2. Under what conditions (including amount, frequency, duration, setting); and

3. Which staff or program will be involved.

4. Specific nursing interventions (as a function of the nursing care plan) will be documented in the column so designated.

E. Definition and Formulation of Target Dates

Target dates should indicate as precisely as possible the anticipated date for attainment of a given goal as measured by performance criteria.

F. Documentation of Patient and Staff Involvement

Both the patient's name and number should be recorded in the appropriate spaces on the Treatment Plan Review Forms. The patient's (if appropriate) signature and that of the patient's primary clinician, the supervising physician (if different than above) and other participating program staff must be present as well. If the patient is under the age of fourteen years, a family member/guardian shall sign the treatment plan. If there is no family member or guardian, that shall be so indicated on the treatment plan review sheet. If the patient refuses to sign the form, or for medical reasons is unable to do so, this should be so noted on the Review Form.

G. Date

The Treatment Plan is dated with respect to its formulation. Treatment Plan reviews are dates as indicated on the Treatment Plan Review Forms.

H. Timetable for Formulation and Revision of Treatment Plans

The initial inpatient treatment plan must be prepared by inpatient programs within 72 hours of admission. This initial plan must address, at a minimum, presenting problems which fall under either AXIS I or II, and AXIS III. As soon thereafter as is possible, the treatment team will address problems relating to AXIS IV and AXIS V.

Treatment plan reviews will occur within the prescribed time frames designated on the Treatment Plan Review Form for both inpatient and outpatient treatment plans. Treatment plan reviews are required to take place every 4 weeks on the inpatient services.

Treatment plans should be prepared by outpatient programs within 15 days of intake. The timing of Treatment Plan revisions will follow time intervals outlined on Outpatient Treatment Plan Review Forms (every 120 days or 15 visits, whichever comes first).

For Partial Hospitalization patients, the initial Treatment Plan is written by the 10th day of assessment and/or treatment and is reviewed by one month and then every 20th day of treatment or two months, whichever comes first, thereafter.

Clinical reviews/revisions as noted on the Treatment Plan Review Form will include: (1) problems resolved; (2) new problems identified; and (3) target dates revised; followed by particular comments, where appropriate, regarding a patient's progress.

In the case of an outpatient who is hospitalized for a period of time exceeding one month, a new Treatment Plan may be required from the outpatient program, unless the previous Treatment Plan, once reviewed, is still pertinent and timely.

I. Designation of Minimal Discharge Criteria resides with the multidisciplinary treatment team, physician and primary clinician, as appropriate. Minimal discharge criteria will be designated for A and B problems only, those problems which relate directly to or precipitated the need for inpatient psychiatric hospitalization. Minimal discharge criteria, which is defined as the resolution of problems which meet criteria for discharge or termination of treatment will be indicated on the treatment plan through the use of an asterisk (*).

J. Progress Notes

1. Inpatient progress notes reflect the multidisciplinary team approach to treatment. While notes may be signed by the team member, they must reflect a particluar team's participation.

2. Inpatient progress notes should be keyed to Problem Categories and Numbers as listed on the TRAIL sheet which will include problems listed on the treatment plan. The specific reference to Problem Category and Number is documented with each entry.

3. Progress notes should be dated and authenticated (complete signature and title or discipline of treating staff).

4. Progress notes should describe the patient's response to the treatment process. Content of the Progress Notes should include the following factors:

   a. The course of treatment of the disorder and results of treatments should be recorded.

   b. Progress or lack thereof toward established treatment goals should be documented.

   c. If there is a lack of progress, documentation of treatment plan revision is noted.

   d. The patient's progress towards discharge and the development of post discharge plans are documented.

Revised: 10/84
3/86
5/87
6/87
7/87
8/87
11/87
5/88
6/88
10/88
Reviewed: 3/89
1/90

TREATMENT PLANS

GENERAL OUTLINE SUMMARY

1. What are the (strengths)?
   - are the abilities?
   - are the environmental supports?
   - are the interests?
   - is the educational attainment level?
   - are the interpersonal skills?
   - are the financial resources?

2. What are the (problems/needs)?
   - are the target behaviors to change?
   - are the medical/psychiatric disabilities?
   - are the baseline behaviors?
   - are the antecedents and consequences of a particular behavior?

3. What are the long term (goals)?
   - are the outcome behaviors?
   - are the predictive statements?
   - are the desired results?
   - are the reflections of problem resolution?

4. What are the (short term goals) (measurable criteria/observable behaviors) that will let us know that the goals are attained?

   - What do we observe?
   - What do we infer?
   - What can we measure (frequency, duration, decreases, increases)?

5. How (Methods) will treatment be carried out?

   - diagnostic procedures
   - individual psychotherapy
   - group
   - referral
   - role-playing
   - charts
   - contracts

   By whom?

   Where?

   How long?

   - Immediacy
   - Frequency
   - Intensity
   - Duration

6. When (Time) will goals be achieved?

   - priorities
   - hierarchies

GOAL ANALYSIS PROCEDURE
EXAMPLE

Step I: Establish the Long Term Goal

To help patient gain more control of impulsive behavior. = Process statement

Patient will have more control of impulsive behavior. = Outcome statement

Step II: "Brain-Storm" ways to measure the long term goals.

No longer striking out at others (hit, kick, bite, pull hair, scratch).
If agitated, he walks away.
Less intrusive.
Able to tolerate meetings.
Take shower without destroying bathroom.
More re-directable.
Able to verbalize.
Able to "stifle" himself.
Not changing clothes as often.
Able to increase number and types of interactions he has.
Can regulate amount of money spent each day.
Requests meds. when feeling agitated.
Doesn't interrupt (disrupt) other groups.
Eats all of meal.
Interacts with family members.
Starts trusting his therapist.
Talks about feeling vs. acting on them.
Cooperative about taking meds.
Stops making attempts to hurt self.
Doesn't attempt to leave hospital (get on elevator, sign AMA, walk out with visitors, hunt for keys, leave lunchroom)
Recognizes problem and is willing to deal with it.
Able to tolerate other patients.

Step III: Sort out short term goals that behaviorally define and measure the attainment of the long term goal.

No longer strikes out at others (hit, kick, bite, pull hair, scratch).
Removes himself from stimulating situation.
Waits till after meetings to ask for something.
Stops walking into meetings or nurses station.
Waits for turn to speak in meetings.
Sits through an entire meeting without screaming out or striking out at others.
Takes showers without destroying bathroom.
Stops impulsive behavior when requested to do so.
Can regulate amount of money spent each day.
Requests medication when agitated.
Talks about what he is feeling rather than acting out.
Does not spit out medication when given.
Stops self-inflicted burns and cuts.
Stops entering elevators, hunting for keys, threatening to leave.

Step IV: Make coherent statements to describe what you intend for each of the short term goals on your list. (Write a complete statement for each short term goal describing the nature, quality, or amount you will consider acceptable.

Long Term Goal: The patient will interact with others in an appropriate manner.

Step IV: Short Term Goals (Performances)

1. The patient will not refer to himself as "a crip", "nothing", or any other deprecating term more than once per contact.

2. The patient will take whatever steps are necessary to clarify questions or issues about which he is confused. His inquiries will be directed to the appropriate people (e.g., medication questions to M.D. or R.N.).

3. The patient will not apologize unless he can supply a clear, concrete reason for apologizing. He will also not apologize for "almost swearing." If he does swear and feels an apology is necessary, he will apologize only once.

4. The patient will apologize only once per contact for: the slowness of his speech; his inability to remember words; and his inability to do certain things such as carry his tray, which makes it necessary for someone else to do it for him.

5. The patient will not ask the person with whom he is speaking if he or she or anyone else is angry with him unless he can: 1) supply a clear reason why the person might be angry, or 2) clearly explain what the person is doing which leads the patient to believe that he or she is angry.

6. The patient will refrain at all times from expressing his anger in a way that could physically harm himself or another person (e.g., hitting, throwing objects).

7. As soon as possible after an incident which angers the patient, he will verbally express his anger in a calm manner to the person with whom he is angry or someone else. This behavior will be encouraged by staff members whenever they perceive the patient's anger.

EXAMPLES OF PROBLEM STATEMENTS UPON WHICH LONG TERM GOAL WAS BASED

1. The patient often refers to himself in depreciating terms, such as "a crip" and "nothing."

2. The patient refrains from asking questions because of a fear of "bothering" others and/or appearing "dumb."

3. The patient often apologizes for no apparent reason or for "almost swearing."

4. The patient often apologizes for aspects of his disability, such as the slowness of his speech, his inability to remember words, and his inability to carry his lunch tray.

5. The patient often asks the person with whom he is speaking if he or she or anyone else is angry.

6. The patient often expresses anger in ways that are potentially harmful to himself and/or others (hitting, throwing objects, etc.).

7. The patient does not express his anger in a constructive manner.

Step V: Test the statements with the following question. If a patient/client achieved or demonstrated each of these short term goals, would I be willing to say he or she has achieved the long term goal? When you can answer yes, the analysis is finished.

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

Patient Name ______________ Hospital No ______________ Program ______________

DATE	PROB NO	PROBLEMS	GOALS AND MEASURABLE PERFORMANCES	METHODS	TARGET DATE	ATTAIN DATE
		1392		1393		

This written document does not constitute a legal contract guaranteeing or promising treatment outcomes.

BEST COPY AVAILABLE

PATIENT RECORD COPY

INSTRUCTIONS AND DEFINITIONS

I. Problems

a. The four categories of problems to be identified are: A. Psychological/ Psychiatric (behaviorally stated); B. Psychophysiologic; C. Physical/Medical; D. Family/Social Network; and E. Environmental (e.g. Housing, Employment, Education, Cultural, Legal). Categories may overlap but they are suggested for the purpose of promoting comprehensiveness rather than imposing a categorization system.

b. Problems can be defined as any event, situation, symptom, behavior, etc. which impairs or interferes with the patient's level of functioning or sense of well being and requires therapeutic intervention.

c. Psychopathological and social functioning problems are formulated in relationship to behaviors. In most cases problem statements will not be represented by traditional psychiatric diagnostic labels.

d. Problem statements that are concise, in clear language, and quantifiable are suggested. Those problem definitions that are best lead most readily to goal statements. Problem statements should be made which are relevant to treatment strategies and intervention.

e. Problems are designated by date of formulation, category and problem number which is not to be thought of as a prioritization of problem importance.

II. Goals and Performances

a. Goals are statements of attainable outcome which are directly related to the resolution of problems cited. There should be a goal statement for each problem. Goals are to be written with the patient's agreement in mind. Although goal statements are abstractions, their measurement, quantification and attainment need to be defined under performance statements.

Performance statements describe specific outcomes that, if achieved, will cause you to agree that the goal is achieved. Performance statements are typically descriptions of a single behavior or class of behaviors that will indicate the presence of an alleged performance about which there would be general agreement. Performances are usually directly observable behaviors or behaviors about whose presence or absence one can make a direct inference. In some cases, measurable performances could be documented through laboratory tests.

b. Performance statements represent observations of frequency, duration, intensity and compliance with respect to the patient's behavior, symptomatology or condition. These performance statements should specify the nat quality or amount of a particular behavior or condition that is considered acceptable.

III. Treatment Methods

Methods will answer the question "How will interventions be carried out to achieve the stated goals and performance measures?" This involves specifying (1) which particular intervention procedures will be utilized; (2) under what conditions (including amount, frequency, duration, setting); and (3) which staff or programs will be involved.

IV. Target and Attainment Dates

Target dates should indicate as precisely as possible the anticipated date for attainment of a given goal as measured by performance criteria.

Attainment date should correspond directly to a review by staff and patient as to the actual accomplishment of the goal and performance measures.

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

PATIENT/CLIENT NAME

PATIENT NUMBER 54321

PROGRAM ______________________________

PATIENT/CLIENT STRENGTHS

Desires to return to state of health	Supportive family and friends	Good work history
Stable marital relationship	Motivated to return to former activities	Previous positive response to medication

DATE	PROBLEM CATEGORY	PROBLEMS/NEEDS		LONG TERM AND SHORT TERM GOALS		METHODS	TARGET DATE
5/86	* A 1	Depressive episode of 2-3 month duration characterized by dysphoria, low self-esteem occasional tearfulness, inability to relax, extended absence from work setting (2 weeks) and suicidal ideation.	A 1	Current symptoms of depression to remit within 4-6 weeks a. patient will report absence of "suicidal ideation" and indicate no further "crying spells" b. patient will report resumption of woodcraft. c. patient will return to work at restaurant	A 1	Intervention: Baseline blood studies, EKG, physical exam, prescribe and monitor antidepressant medication monitor symptom remission, collaboration between physician and primary clinician and marital therapy clinic Frequency or Timing: Tests ordered 5/86 monitor meds, biweekly; therapy sessions weekly Responsible Staff: D. Jarret, M.D.; C. Heape, R.N., Primary Clinician; N. Barber, M.S.W., Family Therapy Clinic	7/86
5/86	A 2	Psychophysiological complaints: sleep disturbance (DFA, SCD, & EM and appetite disturbance (10 lb. weight loss during past two weeks)	A 2	Psychophysiological symptoms remit within 4-6 weeks a. patient reports return to baseline sleeping pattern of 7-8 hours sleep/night over a period of 1 week b. patient reports no continued weight loss. Weight will return to within 10 lbs. of baseline	A 2	Intervention: Antidepressant medication prescribed and monitored, instruct patient in use of sleep and weight log Frequency or Timing: Monitor meds, bi-weekly; weekly review of log Responsible Staff: D. Jarret, M.D.; C. Heape, R.N., Primary Clinician	7/86

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

PATIENT/CLIENT NAME

PATIENT NUMBER 54321

PROGRAM ______________________

E. PATIENT/CLIENT STRENGTHS

Desires to return to state of health	Supportive family and friends	Good work history
Stable marital relationship	Motivated to return to former activities	Previous positive response to medication

DATE	PROBLEM CATEGORY	PROBLEMS/NEEDS	LONG TERM AND SHORT TERM GOALS	METHODS	TARGET DATE
6/86	D	Marital discord: unresolved conflicts resulting from husband's contention that patient should relinquish current occupation and career aspirations in order to remain home to raise a family	D Patient reports improved marital relationship a. patient states that issue of raising a family has been resolved to mutual satisfaction of patient and spouse b. patient reports that she is more comfortable in expressing her feelings/expectations with spouse	D Intervention: Conjoint marital therapy through Family Therapy Clinic will subsequently be evaluated and possibly renewed Frequency or Timing: 8 sessions Responsible Staff: M. Barber, M.S.W., Family Therapy Clinic	7/86

(Asterisk) indicates minimal discharge criteria

Primary Clinic	
Other Clinical Service	
Patient's Name	
Patient's Number	

University of Pittsburgh Medical Center

Western Psychiatric Institute & Clinic
3811 O'Hara Street, Pittsburgh, PA 15213-3241

TREATMENT PLAN REVIEW
OUTPATIENT

I have been involved in developing my treatment plan, had the opportunity to ask questions and I accept and fully consent to the plan for my treatment on the dates indicated below:

TIME INTERVAL	DATE	CLINICAL REVIEW/REVISIONS	*CLINICAL SIGNATURES	PATIENT SIGNATURE
Comprehensive Treatment Plan Within 15 days of Intake				
Every 120 days or 15 visits whichever comes first				
Every 120 days or 15 visits whichever comes first				
Every 120 days or 15 visits whichever comes first				1400

1399

*Primary Clinician AND Psychiatrist or Physician of Record

ITEM #811600 (Rev. 1/84)

TREATMENT PLANS

GENERAL DIRECTIONS

A. On the Treatment Plan Request Form (see example below) please fill in:

(1) Patient's complete name and preferred first name, separately
(2) Patient's number
(3) Treatment Plan file name and number (see attached)
(4) Problem number (E 1, E 2, etc.)
(5) Clinician's name
(6) Date to be returned to clinician

B. Upon receipt of Treatment Plan from clinic secretary:

(1) Edit; make corrections.
(2) Write in target date for each short term goal and the overall longterm goal.
(3) Write in patient's strengths and patient's working diagnoses (Axis I & II).

C. When reviewing Treatment Plans with patient:

(1) Obtain feedback and make any additional corrections.
(2) Obtain patient's signature on Treatment Plan review sheet.
(3) Initial date on Treatment plan review sheet should be 15 days from date of first meeting.
(4) Review dates must be within 120 days of each other.
(5) Student and clinician signature must be co-signed by clinic supervisor.
(6) Give the patient the de-identified copy of the Treatment Plan; Clinic copy to be retained in clinician's file; Patient Record copy to be returned to medical records with Treatment Plan Review sheet attached.

TREATMENT PLAN REQUEST FORM

Patient Complete Name & Preferred First Name Separately:

_______________ _________

Hospital Number: ________

File Name or Number ________.**TRT** (see index)

Date: ______

Target Dates:

Long Term Goal: ______

Short Term Goals: 1.______ 2.______ 3.______ 4.______

5.______ 6.______ 7.______

Problem: E ______

Clinician: __________

Date to be returned to clinician: ______

1401

Index for Treatment Plans

File Name	File #	Description
ABSENCE.TRT	1	lacks nonemployment activities which are meaningful and productive
ASSIST.TRT	2	requests assistance with implementing plan to attend educational/training program
DIFFICUL.TRT	3	is experiencing difficulty in academic/training setting
ACADTRB.TRT	4	reports difficulty in previous attempt(s) at obtaining advanced educational credentials
HI-INTER.TRT	5	expresses high interest in ________ - related jobs but is unsure of current skills and necessary prerequisites
IMPROVE.TRT	6	wishes to improve the following job seeking skills:
NOCOLLEG.TRT	7	college matriculation is currently not a viable option
PRE-VOC.TRT	8	is in need of work readiness activities and developmental work experiences
SKILLS.TRT	9	is dissatisfied with present levels of basic academic skills
SOLITARY.TRT	10	has poorly developed interpersonal skills, i.e.:
UNCERTAI.TRT	11	is uncertain regarding career goals and courses of action to take
FEAR.TRT	12	expresses concerns and/or fears about becoming employed, i.e.
WORKMAIN.TRT	13	wishes to maintain employment over extended period of time and increase confidence in own capabilities re: work
SCHOOLMAIN.TRT	16	desires support and advisement while in current educational/training program

Examples of Patient Strengths for use in treatment planning:

Axis I
1. Compliant with treatment regimen
2. Understanding of nature of illness
3. Can identify prodromal symptoms
4.
5.
6.

Axis II
1. Educational attainment
2. Above average intelligence
3. Persistent goal-oriented behavior
4. Perseveres with tasks
5. Follows through on plans
6. Good social judgment
7. Seeks consultation/help when needed
8. Highly motivated
9.
10.
11.

Axis III
1. Physical stamina
2. Good general physical health
3.
4.
5.

Axis IV
1. Good interpersonal support system
2. Currently employed
3. Stable housing
4. Adequate income
5. Receives income maintenance
6. Reliable child care arrangements
7. OVR sponsorship
8. Student financial aid
9. Good work history
10.
11.
12.

NOTE: The above lists are not exhaustive and are intended as useful examples. Please individualize as needed in developing individual patient treatment plans.

E__

_____ lacks non-employment activities which are meaningful and productive

Strengths:

Diagnosis:

Axis I:

____

____

Axis II:

____

____

Long Term Goal:

_____ will have engaged in meaningful and productive non-employment activities which meet personal needs.

Short Term Goals:

1. _____ will explore and identify interests in the areas of:

_____ social clubs and activities

_____ health/fitness

_____ volunteer services

_____ leisure learning/self-development

_____ entertainment

_____ arts and crafts

_____ other ___________________________

NARS clinician, _____, will meet with _____ on a _____ monthly basis to assist in:

a. identifying community resources and vocational opportunities

b. the development of a realistic plan of action.

NARS clinician, _____, will provide support to _____ throughout the exploration and implementation of a plan of action.

NARS clinician, _____, will enlist the input of significant others as appropriate.

2. _____ will identify ways to become involved in high interest areas, i.e., volunteer service, non-credit courses, etc...

3. _____ will explore and discuss feelings around the personal meaning of employment and non-employment activities.

4. _____ expresses satisfaction with interests and activities.

E__

_____ requests assistance with implementing plan to attend educational/training program, i.e., meeting deadlines, registration process, accessing financial resources, budgeting, course selection.

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:

_____ will have a thorough understanding of college degree/training program requirements and procedures for meeting these.

Short Term Goals:

1. _____ has verified program costs and financial aid sources (PELL, PHEAA, loans, OVR, work study), application forms, deadlines for application, and eligibility criteria (default income/guidelines).

2. _____ has verified admission/acceptance criteria (pre-requisites, academic standing, transfer credits, transcripts, deadlines).

NARS clinician, _____, will provide on a _____ individual outpatient basis:

a. career counseling and guidance

b. education regarding community education and training institutions

c. referral and liaison services as indicated

3. _____ has verified course registration process (advisor, nature of courses, course selection, credit hours, class time-schedule deadlines).

4. _____ has verified degree/program requirements (starting times, full or part-time options, length of program curriculum content).

5. _____ has developed a written workable time activity schedule which allows for educational, mental health, personal, employment and other significant needs and goals.

E__

_____ is experiencing difficulty in academic/ training setting, i.e., study habits, class attendance, passing grades; confidence in personal ability to complete educational/ training program.

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:

_____ will have accommodated to the demands of a particular educational/training program while continuing to meet other life obligations, i.e., good mental and physical health, financial security, family obligations.

Short Term Goals:

1. _____ arranges time and activities to allow for 100% attendance of all scheduled classes and homework/study time as indicated by program demands.

2. _____ has reviewed requirements for each course (i.e., essay tests, homework assignments, weekly quizzes, term papers, lab reports).

NARS clinician, _____, will provide on a _____ monthly basis through individual counseling sessions:

a. training and assistance with educational survival skills (study skills, note taking strategies, use of resources, test taking strategies)

b. career exploration assistance

c. referral and liaison activities as indicated

d. monitoring of _____ progress

3. _____ will review current methods of study (i.e., note taking, outlining/organizing course material, study habits) and how to improve them.

4. _____ will investigate and utilize available student services/resources, i.e.,

____

____

5. _____ will review progress in program on a regular basis, identify problem areas, and develop specific interventions for these.

E__

_____ reports difficulty in previous attempt(s) at obtaining:

___ General Equivalency Diploma (GED)

___ professional certification

___ college credits

___ college degree

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:
_____ will have an understanding of the necessary requirements to obtain __________ and a realistic self-appraisal of the abilities and resources necessary to obtain this goal

Short Term Goals:
1. _____ will explore previous attempt(s) to assist with the current appraisal.

2. _____ will complete an assessment of current levels of academic skills and use these results in planning.

3. _____ will investigate available resources to obtain the stated goal.

4. _____ can specifically identify individual strengths and weaknesses and how they relate to the educational objective.

NARS clinician, _____, will provide on a _____ basis through individual counseling sessions:

a. an assessment of academic achievement and vocational guidance based on test results

b. referral and liaison activities as indicated

c. monitoring and support of _____ self-appraisal and resource investigation

E__

_____ expresses high interest in ________-related jobs but is unsure of current skills and necessary prerequisites

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:

_____ will have a thorough understanding as to whether the ________-related professions are compatible with _____ 's skills, interests, work preferences, physical limitations, and stress tolerance level.

Short Term Goals:

1. _____ will explore varied ________- related career information via utilization of NARS resource materials.

2. _____ will participate in formal vocational assessment, review results with NARS clinician, _____, and discuss implications for career choice.

NARS clinician, _____, will provide on a _____ monthly basis through individual counseling sessions:

a. vocational assessment and guidance

b. career exploration resources

c. education and feedback

d. referral and liaison activities as indicated

e. monitoring of _____ 's progress

3. _____ will list pros/cons of a chosen career direction.

4. If deemed necessary, _____ will further explore career information related to assessment results in order to clarify alternatives.

5. _____ utilizes volunteer work to aid in career decision making and determining work tolerance level.

6. _____ will visit 2-3 job sites where a specific job can be observed.

7. _____ will select a specific job site and follow through with shadowing and/or informational interviewing a particular staff member there.

E__

_____ wishes to improve the following job seeking skills:

___ personal appearance

___ conversational skills

___ self-confidence

___ demonstrating enthusiasm to work

___ resume preparation

___ job application completion

___ generating job leads

___ following-up on job leads

Long Term Goal:

_____ demonstrates specific improved job seeking skills in an active job search.

Short Term Goals:

1. _____ considers volunteer work to aid in building work tolerance and obtaining a current work reference.
2. _____ has produced an updated resume and a master sample job application and uses them in an active job search.
3. _____ has practiced and improved verbal and nonverbal skills essential to the job interviewing process.

NARS clinician, _____, will provide:

a. individual counseling on a _____ monthly basis.

b. administration of a vocational assessment battery.

c. review of assessment results.

d. career exploration guides and resources.

e. assistance and instruction in the Job Seeking Skills process.

NARS clinician, _____, will conduct a _____ week Job Seeking Skills Group.

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

4. _____ has learned to generate job leads; i.e., use of want ads, the Pittsburgh Alliance, other community resources, independent searches.

5. _____ has followed-up on job leads, i.e., calls employer, sends in resume and cover letter, completes job application forms.

6. _____ participates in Job Seeking Skills Group.

7. _____ has verified the usability of former work references.

E__

_____ 's college matriculation currently is not a viable option; _____ needs to learn job skills in order to enhance employability

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:

_____ will have developed a realistic and feasible rehabilitation plan in lieu of pursuing a formal academic program at this time.

Short Term Goals:

1. _____ will acknowledge that at this point in time college level academic training is not a viable option due to:

_____ a. concentration problems

_____ b. academic deficits

_____ c. lack of funding

_____ d. other

____

____

NARS clinician, _____, will meet with _____ on a _____ monthly basis in order to:

a. administer formal vocational assessment

b. review results with _____ and provide assistance and guidance with integrating results into vocational / educational planning

c. referral and liaison services as needed

Career information resources will be available in the NARS clinic as well as instruction on resource utilization.

2. _____ will engage in vocational assessment in NARS, reviewing results with NARS clinician, _____.

3. _____ will demonstrate that the results of testing are understood by utilizing the information to list vocational training options which are compatible with documented interests, aptitudes, work values, and academic skills.

4. _____ will meet with OVR counselor to determine eligibility for services and subsequent discussion of programming needs.

5. _____ will visit job training site to determine whether or not it is suitable.

#8 PREVOC.TRT

E__

_____ is in need of work readiness activities and developmental work experiences.

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:

_____ will have demonstrated those basic behaviors, habits, and attitudes which are required in the role of worker.

Short Term Goals:

1. _____ is able to realistically assess present readiness for employment/training in terms of:

_____ stamina and mental endurance

_____ time management

_____ incorporating work into ongoing life style

_____ ability to identify/meet demands of employment, i.e., use of sick time, interactions with co-workers, task performance

NARS clinician, _____, will provide _____ monthly through individual counseling sessions:

a. vocational assessment and guidance

b. career exploration resources

c. education and feedback

d. referral and liaison activities as indicated

e. monitoring of _____ 's progress

_____ realistic estimation of own capabilities

2. _____ engages in a functional assessment of work/training readiness

___ participation in a structured volunteer experience in high interest areas

___ participation in a period of personal work adjustment and skill training

___ completion of a single "trial" course in a vocational area of interest

#9 SKILLS.TRT

E__

_____ is dissatisfied with present levels of basic academic skills.

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

Long Term Goal:

_____ will follow through on a plan to improve basic academic skills.

Short Term Goals:

1. _____ will review previous attempts at schooling/training as an aid in current planning.

2. _____ will take part in an assessment of current academic skill levels and academic survival skills.

3. _____ will investigate and utilize available resources for developing desired skills, i.e., pre-college programs, literacy training, developmental courses, Adult Basic Education.

NARS clinician, _____, will provide _____ through individual counseling sessions:

a. academic testing and guidance

b. review of testing results

c. referral and liaison activities as indicated

d. monitoring of _____ 's progress

e. instruction in academic survival skills

4. _____ will identify problem areas which interfere with the academic plan, and develop effective ways of dealing with them.

E__

_____ has poorly developed interpersonal skills, i.e.:

___ poor eye contact

___ difficulty starting a conversation

___ changing affect to meet demands of the situation

___ sexually provocative comments

___ inability to judge personal space needs of others

Long Term Goal:

_____ will demonstrate an improved ability to interact with others, particularly in the work place.

Short Term Goals:

1. _____ will participate in social skills training at _________________.

2. _____ will engage in volunteer work commencing with 4 hours per week and subsequently increasing hours (in 4 hour increments) to _____ hours per week.

3. _____ will maintain a log of interpersonal experiences (both positive and negative) and discuss specific experiences with NARS clinician.

NARS clinician, _____, will:

a. meet with _____ on a _____ monthly basis to:

b. utilize role play activity which will focus on problematic interpersonal situations.

c. provide referral and liaison activities as indicated.

d. monitor _____ 's progress in an ongoing manner, providing feedback as appropriate.

e. suggest real-life activities in which _____ may participate.

Strengths:

Diagnosis:

Axis I

____

____

Axis II

____

____

4. _____ will engage in simulated interpersonal situations with NARS clinician and demonstrate improved conversational/nonverbal behavior.

5. _____ will participate in real-life experiences where _____ can learn and practice social skills.

E__	_____ is uncertain regarding career goals and courses of action to take: ___ a. previous academic failures resulting in decreased sense of self-worth ___ b. unable to return to previous career ___ c. dissatis-faction with current job; desires to explore alternatives ___ d. lack of or limited employment experiences	Long Term Goal: _____ will have established and followed through on a plan of action to aid in determining specified vocational goal(s). Short Term Goals: 1. _____ will review previous educational and vocational experiences to aid in current planning. 2. _____ will complete a vocational assessment battery. 3. _____ will utilize results of vocational assessment in career exploration. 4. _____ will explore areas of high interest and career alternatives/training options utilizing discussion with clinician and career/educational	NARS clinician, _____ will provide: individual vocational counseling on a _____ monthly basis which will include the administration of a vocational assessment battery, reviewing assessment results, providing career exploration and guidance, providing supportive services regarding _____'s plan of action, and referral and liaison services as indicated.

___ e. unclear whether stated career goal is feasible

Strengths:

Diagnosis:

Axis I:

____

____

Axis II:

____

____

resource materials.

5. _____ will investigate employment options while exploring educational opportunities.

6. _____ will investigate educational options within the local community.

7. _____ will begin to take classes in an area of interest related to a defined career goal.

8. _____ can identify personal strengths and abilities and realistically appraise personal limitations.

9. _____ will identify pros and cons of potential career direction.

10. _____ will report an increased sense of self confidence.

11. _____ considers volunteer work to aid in career decison making and determining work tolerance level.

E__ _____ expresses concerns and/or fears about becoming employed, i.e.

___ child care arrangements

___ change in benefits

___ scheduling usual activities of daily life

___ ability to meet increased job performance demands

___ leaving volunteer position for paid employment

___ loss of current supports

___ transportation

Long Term Goal:

_____ understands and can incorporate the consequences of being employed into current lifestyle and will utilize this information in future career exploration.

Short Term Goals:

1. _____ lists current benefits and income from all sources.

2. _____ can evaluate and compare potential employment with current benefits and income.

3. _____ explores options for ensuring that _____ needs are met.

4. _____ can discuss feelings about changes in current support system.

NARS clinician, ________, will provide vocational counseling and guidance that is focused on:

___ reviewing benefits

___ evaluating employment options

___ identifying stress management activities and resources

___ identifying appropriate community and "natural" supports

___ other:

Strengths:

5. _____ can identify means of dealing with increased stressors/ demands.

Diagnosis:

Axis I:

____

____

Axis II:

____

____

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

Patient Name #13 WORKMAIN.TRT Hospital No ____________ Program ____________

DATE	PROB NO	PROBLEMS	GOALS AND MEASURABLE PERFORMANCES	METHODS	TARGET DATE	ATTAIN DATE
E__		_____ wishes to maintain employment over extended period of time and increase confidence in own capabilities regarding work	**Long Term Goal:** _____ reports greater confidence in own capability to make satisfactory adjustments on the job and confidence in own ability to maintain employment over extended periods. **Short Term Goals:** 1. _____ can identify the major responsibilities and tasks of employment and effective ways of fulfilling these. 2. _____ can identify and keep within both overt and covert "norms" re: acceptable interpersonal behavior at work. 3. _____ will ask for assistance when unclear about work duties, procedures, or priority	MARS clinician will provide supportive counseling and guidance on an individual outpatient basis every 6-8 weeks, and by telephone as needed; liaison services as needed		

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PH 1048 (2/80)

PATIENT R[illegible]RD COPY

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

Patient Name: ____________________ Hospital No.: ____________ Program: ______________________

DATE	PROB NO	PROBLEMS	GOALS AND MEASURABLE PERFORMANCES	METHODS	TARGET DATE	ATTAIN DATE
			assignments. 4. _____ will ask for help when work becomes excessively backed up and before feeling overwhelmed and overly stressed. 5. _____ can identify and make adjustments in lifestyle to accommodate demands of being employed, i.e., ___ sleep schedule ___ child care, family obligations ___ transportation ___ changes in benefits			

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CLINIC COPY

E__

_____ desires support and advisement while in current educational/training program.

Strengths:

Diagnosis:

Axis I:

____

____

Axis II:

____

____

Long Term Goal:
_____ demonstrates competencies with regard to the ability to make satisfactory adjustments in educational/training related activities.

Short Term Goals:
1. _____ has applied in a timely fashion for financial aid (PELL, PHEAA, OVR, work study).

2. _____ has registered for appropriate courses and verified degree/program requirements per academic year.

3. _____ will review and discuss evaluations, assignments, and feedback received in terms of performance in the classroom setting each semester.

NARS clinician, _____, will provide supportive counseling and guidance on an individual outpatient basis (_____):

a. utilize role play activity focused on improving problematic interpersonal skills in the context of the educational/training setting

b. provide career/academic counseling and guidance with respect to course selection and program of study.

c. training and assistance in academic survival skills, i.e. study skills, note taking strategies, test taking strategies, use of resources.

4. _____ has learned to request clarification, feedback, and assistance from instructor and/or fellow students when unclear about assignments and performance.	d. referral and liaison activities with school and rehabilitation personnel as indicated
5. _____ maintains a log of interpersonal experiences (both positive and negative) which occur in training and discusses these with NARS clinician.	
6. _____ actively utilizes academic survival skills and strategies in the educational setting.	

CRITICAL SKILLS CHECKLIST

Client name ______________________ Evaluator ______________________

ID Number ______________________ Agency ______________________

Date ______________

INSTRUCTIONS: Circle the appropriate category indicating how well each of the following critical skills are performed according to the definition key below:

Very Poor (1) - skill performance is very poor or absent

Poor (2) - skill performance is poor or inconsistent at best

Adequate (3) - skill performance is adequate (meets current needs)

Good (4) - skill performance is good (effective, consistent/efficient)

Superior (5) - skill performance is highly satisfactory (particular strength)

No (N) - cannot be determined; skill performance in need of further evaluation

The Environmentally Specific Comments section is used to specify environmental and behavioral parameters in summarizing skill performance, i.e., quantity: frequency, duration, consistency, reliability; quality: thoroughness, accuracy, desirability, expediency, efficacy; and level of independence: level/frequency of supervision, prompting. Comments here should further elucidate client strengths which may be capitalized upon, as well as deficit areas which may be targeted for intervention.

Specify the environment for which this assessment was completed: ______________________

____

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A. LANGUAGE/COMMUNICATION

- engages in every day conversation	1	2	3	4	5	N
- understands verbal commands, directions	1	2	3	4	5	N
- responds to nonverbal contextual cues	1	2	3	4	5	N
- expresses needs & feelings	1	2	3	4	5	N

Environmentally Specific Comments:

B. MEMORY AND LEARNING

- recalls basic environmental information (names, address,telephone and Social Security number, simple directions)	1	2	3	4	5	N
- remembers appointment times and schedule of activities	1	2	3	4	5	N
- recalls long-term information (work or educational history)	1	2	3	4	5	N
- comprehends written materials	1	2	3	4	5	N
- learns from hands-on experience	1	2	3	4	5	N
- learns from verbal instructions	1	2	3	4	5	N

Environmentally Specific Comments:

C. ATTENTION/CONCENTRATION

- sustains attention to aurally presented information	1	2	3	4	5	N
- sustains attention to task task at hand	1	2	3	4	5	N

Environmentally Specific Comments:

D. PROBLEM SOLVING AND CONCEPTUALIZATION

- makes reasonable decisions	1	2	3	4	5	N
- formulates a plan	1	2	3	4	5	N
- carries out a plan	1	2	3	4	5	N
- generalizes a concept across settings	1	2	3	4	5	N
- responds to constructive criticism	1	2	3	4	5	N

Environmentally Specific Comments:

E. DAILY LIVING

- attends to personal hygiene (shower, shampoo, deodorant)	1	2	3	4	5	N
- uses a telephone	1	2	3	4	5	N
- engages in leisure time activities	1	2	3	4	5	N
- reads a newspaper	1	2	3	4	5	N
- budgets money	1	2	3	4	5	N
- plans a nutritionally balanced meal	1	2	3	4	5	N
- prepares meals adequately	1	2	3	4	5	N
- shops for personal items	1	2	3	4	5	N
- uses public transportation	1	2	3	4	5	N
- accesses necessary resources (Social Security, Medical care, etc.)	1	2	3	4	5	N

Environmentally Specific Comments:

F. SELF APPRAISAL AND JUDGMENT

- evaluates severity of external stressors	1	2	3	4	5	N
- copes with mild stress	1	2	3	4	5	N
- seeks support if unduly stressed	1	2	3	4	5	N
- verbalizes relevant and appropriate personal goals	1	2	3	4	5	N

Environmentally Specific Comments:

G. STAMINA AND TOLERANCE

- tolerates a 6-8 hour workday	1	2	3	4	5	N
- lifts objects 35-50 lbs	1	2	3	4	5	N
- traverses 100 yards without fatigue	1	2	3	4	5	N

Environmentally Specific Comments:

KEY:
1 = Very Poor
2 = Poor
3 = Adequate
4 = Good
5 = Superior
N = In need of further evaluation

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CRITICAL SKILLS CHECKLIST

Client name Sam

Evaluator M. Geckle, M.Ed., CRC

ID Number

Agency NARS, WPIC

Date 10/10/84

INSTRUCTIONS: Circle the appropriate category indicating how well each of the following critical skills are performed according to the definition key below:

Very Poor (1) - skill performance is very poor or absent

Poor (2) - skill performance is poor or inconsistent at best

Adequate (3) - skill performance is adequate (meets current needs)

Good (4) - skill performance is good (effective, consistent/efficient)

Superior (5) - skill performance is highly satisfactory (particular strength)

No (N) - cannot be determined; skill performance in need of further evaluation

The Environmentally Specific Comments section is used to specify environmental and behavioral parameters in summarizing skill performance, i.e., quantity: frequency, duration, consistency, reliability; quality: thoroughness, accuracy, desirability, expediency, efficacy; and level of independence: level/frequency of supervision, prompting. Comments here should further elucidate client strengths which may be capitalized upon, as well as deficit areas which may be targeted for intervention.

Specify the environment for which this assessment was completed: Personal Work Adjustment Training, janitorial, TE and job placement process

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A. LANGUAGE/COMMUNICATION

- engages in every day conversation 1 2 [✓ 3] 4 5 N
- understands verbal commands, directions 1 [✓ 2] 3 4 5 N
- responds to nonverbal contextual cues 1 [✓ 2] 3 4 5 N
- expresses needs & feelings 1 2 [✓ 3] 4 5 N

Environmentally Specific Comments:
Janitorial and personal work adjustment training program - may need written cue cards for multi-step tasks and instructions

B. MEMORY AND LEARNING

- recalls basic environmental information (names, address,telephone and Social Security number, simple directions) 1 2 [✓ 3] 4 5 N
- remembers appointment times and schedule of activities 1 2 [✓ 3] 4 5 N
- recalls long-term information (work or educational history) 1 [✓ 2] 3 4 5 N
- comprehends written materials 1 [✓ 2] 3 4 5 N
- learns from hands-on experience 1 2 3 [✓ 4] 5 N
- learns from verbal instructions 1 [✓ 2] 3 4 5 N

Environmentally Specific Comments:
'll need brief, concise, written instruc-
.ions throughout training and placement

C. ATTENTION/CONCENTRATION

- sustains attention to aurally presented information 1 [✓ 2] 3 4 5 N
- sustains attention to task task at hand 1 [✓ 2] 3 4 5 N

Environmentally Specific Comments:
Does respond well to redirection to task at hand

D. PROBLEM SOLVING AND CONCEPTUALIZATION

- makes reasonable decisions 1 [✓ 2] 3 4 5 N
- formulates a plan 1 [✓ 2] 3 4 5 N
- carries out a plan 1 [✓ 2] 3 4 5 N
- generalizes a concept across settings 1 [✓ 2] 3 4 5 N
- responds to constructive criticism 1 2 [✓ 3] 4 5 N

Environmentally Specific Comments:
Overall greatest deficit area; will need flexible, comprehensive, and long-term case management services

E. DAILY LIVING

- attends to personal hygiene (shower, shampoo, deodorant) 1 2 3 [✓ 4] 5 N
- uses a telephone 1 2 3 [✓ 4] 5 N
- engages in leisure time activities 1 2 3 [✓ 4] 5 N
- reads a newspaper 1 [✓ 2] 3 4 5 N
- budgets money 1 [✓ 2] 3 4 5 N
- plans a nutritionally balanced meal 1 2 [✓ 3] 4 5 N
- prepares meals adequately 1 2 [✓ 3] 4 5 N
- shops for personal items 1 2 [✓ 3] 4 5 N
- uses public transportation 1 2 3 [✓ 4] 5 N
- accesses necessary resources (Social Security, Medical care, etc.) 1 2 [✓ 3] 4 5 N

Environmentally Specific Comments:
Needs help with written monthly budget; difficulty reading want-ads and job applications - needs prewritten applications and help with job leads &/or direct, selective placement

F. SELF APPRAISAL AND JUDGMENT

- evaluates severity of external stressors 1 [✓ 2] 3 4 5 N
- copes with mild stress 1 2 [✓ 3] 4 5 N
- seeks support if unduly stressed 1 [✓ 2] 3 4 5 N
- verbalizes relevant and appropriate personal goals 1 2 [✓ 3] 4 5 N

Environmentally Specific Comments:
Needs close, active monitoring throughout training and on TE and competitive job; may "oversocialize" at work-spend excessive time conversing with coworkers

G. STAMINA AND TOLERANCE

- tolerates a 6-8 hour workday 1 2 [✓ 3] 4 5 N
- lifts objects 35-50 lbs 1 2 3 [✓ 4] 5 N
- traverses 100 yards without fatigue 1 2 3 4 [✓ 5] N

Environmentally Specific Comments:
Relative strengths in this area; enjoys work that is physical in nature and outdoors

KEY:
1 = Very Poor
2 = Poor
3 = Adequate
4 = Good
5 = Superior
N = In need of further evaluation

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PSYCHOSOCIAL SUMMARY

Client Name ____________________ Evaluator ____________________________

ID Number ______________________ Agency ______________________________

Date __________________________

Basic Environmental Supports

Does the client have an effective support system?

Family ____ Y ____ N

Peer ____ Y ____ N

Institutional ____ Y ____ N

Does the client maintain a stable residence? ____ Y ____ N

Is the client active with a MH provider? ____ Y ____ N

Specify corrective action if necessary:

____

____

____

Physical Health

Are there significant physical health problems? ____ Y ____ N

Describe (i.e., well-controlled, may complicate programming):

____

____

____

If indicated, is follow-up provided? ____ Y ____ N

Describe (i.e., where, by whom, how often):

____

____

____

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Psychiatric Status

Check for the presence of any major symptom cluster

	If Present:	Acute	Chronic/Residual	In Remission
____	Psychotic Experiences	____	____	____
____	Depression	____	____	____
____	Manic Symptoms	____	____	____
____	Anxiety or Fears	____	____	____
____	Obsessions or Compulsions	____	____	____
____	Organic Dysfunction	____	____	____
____	Drug Abuse	____	____	____
____	ETOH Abuse	____	____	____
____	Suicide Attempts	____	____	____
____	Other Symptoms	____	____	____

Specify action necessary around any current symptoms manifestation:

____

____

____

____

Has the client demonstrated consistent medication compliance? ____ Y ____ N

For how long? ____________________

Intrapersonal Factors:

Can client readily discuss impact of his symptoms on behavior and lifestyle? ____ Y ____ N

If no, does he/she tend to:

________ Deny

________ Avoid

________ Use Sick Role

Client's personal rehabilitation aims/personal incentives toward change:

Noteworthy disincentives toward maintenance of employment:

PSYCHOSOCIAL SUMMARY

Client Name Sam

ID Number

Date 4-17-84

Evaluator M. Geckle, M.Ed., CRC

Agency NARS, WPIC

Basic Environmental Supports

Does the client have an effective support system?

Family	X Y	N
Peer	Y	X N
Institutional	x Y	N
Does the client maintain a stable residence?	Y	X N
Is the client active with a MH provider?	X Y	N

Specify corrective action if necessary:

Sam is continuously between his mother's and his girlfriend's home, however he does not express dissatisfaction with this arrangement, as his mother is in poor health. Sam has few friends, social/recreational outlets.

Physical Health

Are there significant physical health problems?	X Y	N

Describe (i.e., well-controlled, may complicate programming):

deteriorated root canal

chest pains of 2/84 now resolved

R/O bladder infection

If indicated, is follow-up provided?	x Y	N

Describe (i.e., where, by whom, how often):

referred to Montefiore Dental Clinic and Primary Medical Care Unit, WPIC

© Psychiatric Rehabilitation Training Program, Western Psychiatric Institute and Clinic, University of Pittsburgh

Psychiatric Status

Check for the presence of any major symptom cluster

	If Present:	Acute	Chronic/Residual	In Remission
	Psychotic Experiences			X
	Depression			
	Manic Symptoms			X
	Anxiety or Fears			
	Obsessions or Compulsions			
	Organic Dysfunction			
	Drug Abuse			X
	ETOH Abuse			X
	Suicide Attempts			
	Other Symptoms			

Specify action necessary around any current symptoms manifestation:

Ongoing monitoring of medications including regular blood levels;
psychiatrically stable at this time; no noted use of drugs or ETOH since 1971

Has the client demonstrated consistent medication compliance? X Y ___ N

For how long? 7/82 to present

Intrapersonal Factors:

Can client readily discuss impact of his symptoms on behavior and lifestyle? X Y ___ N

If no, does he/she tend to:
___ Deny
___ Avoid
___ Use Sick Role

Client's personal rehabilitation aims/personal incentives toward change:

Sam is motivated to increase his real income to improve his family's standard of living. He desires to be productively engaged and to improve his lifestyle - "hangin' out on street corners and gettin' into trouble is just not for me". He is concerned about a pension/retirement plan - he wants to obtain employment with an established, reputable employer and to maintain this job over an extended period of time - "this one I'm going to retire on." Sam is strongly motivated to "stay out of the hospital." He states, "I just want to be like anybody else, have a job."

Noteworthy disincentives toward maintenance of employment:

None major at present with the possible exception of: 1) loss of medical coverage under Medical Assistance; 2) part-time (approx. 25 hrs./wk.) employment would ne Sam approximately the equivalent per month of his current Public Welfare cash grant ($195.00) and Food Stamp allottment ($95.00). Sam greatly desires to increase his real income/month, but is willing to begin any part-time job, even one which pays the minimum wage, if full-time hours and incremental pay raises are realistic/likely possibilities.

PATIENT'S ASSESSMENT OF OWN FUNCTIONING INVENTORY

____
Patient Name

____
Date

Manner of Inventory Administration:

- ( ) Patient read and answered items independently
- ( ) Items read to patient by examiner
- ( ) Examiner marked answers given verbally by patient
- ( ) Examiner read items to patient and marked his/her verbally given answers

Patient Assessment of Own Functioning Inventory
Chelume, Heaton and Lehman

SCALE I: MEMORY

Instructions: Please answer each of the following questions by placing a check next to the response which most accurately describes the way you have been recently.

1. How often do you forget something that has been told you within the last day or two?

(M-1)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

2. How often do you forget events which have occurred in the last day or two?

(M-2)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

3. How often do you forget people whom you met in the last day or two?

(M-3)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

4. How often do you forget things that you knew a year or more ago?

(M-4)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

5. How often do you forget people whom you knew or met a year or more ago?

(M-5)
- ( ) almost always
- ( ) very often
- ( ) fairly often
- ( ) once in a while
- ( ) very infrequently
- ( ) almost never

6. How often do you lose track of time, or do things either earlier or later than they are usually done or are supposed to be done?

(M-6)
- ( ) almost always
- ( ) very often
- ( ) fairly often
- ( ) once in a while
- ( ) very infrequently
- ( ) almost never

7. How often do you fail to finish something you start because you forgot that you were doing it? (Include such things as forgetting to put out cigarettes, turn off the stove, etc.)

(M-7)
- ( ) almost always
- ( ) very often
- ( ) fairly often
- ( ) once in a while
- ( ) very infrequently
- ( ) almost never

8. How often do you fail to complete a task that you start because you have forgotten how to do one or more aspects of it?

(M-8)
- ( ) almost always
- ( ) very often
- ( ) fairly often
- ( ) once in a while
- ( ) very infrequently
- ( ) almost never

9. How often do you forget things that you are supposed to do or have agreed to do (such as putting gas in the car, paying bills, taking care of errands, etc.)?

(M-9)
- ( ) almost always
- ( ) very often
- ( ) fairly often
- ( ) once in a while
- ( ) very infrequently
- ( ) almost never

SCALE II: LANGUAGE AND COMMUNICATION

Instructions: Please answer each of the following questions by placing a check next to the response which most accurately describes the way you have been recently.

1. How often do you have difficulties understanding what is said to you?

(LC-1)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

2. How often do you have difficulties recognizing or identifying printed words?

(LC-2)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

3. How often do you have difficulty understanding reading material which at one time you could have understood?

(LC-3)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

4. When you speak, are your words indistinct or improperly pronounced?

(LC-4)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, how often do people have difficulty understanding what words you are trying to say?

(LC-5)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

5. How often do you have difficulty thinking of the names of things?

(LC-6)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

6. How often do you have difficulty thinking of the words (other than names) for what you want to say?

(LC-7)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

7. When you write things, how often do you have difficulty forming the letters correctly?

(LC-8)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

8. Do you have more difficulty spelling, or make more errors in spelling, than you used to?

(LC-9)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

SCALE III: USE OF HANDS

Instructions: Please answer these questions in the same way as the previous scales. Just put a check next to the response which most accurately describes the way you have been lately.

1. How often do you have difficulty performing tasks with your right hand (including such things as writing, dressing, carrying, lifting, sports, cooking, etc.)?

(Hands-1)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

2. How often do you have difficulty performing tasks with your left hand?

(Hands-2)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

SCALE III (2): SENSORY-PERCEPTUAL

1. How often do you have difficulty feeling things with your right hand?

(Percept-1)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

2. How often do you have difficulty feeling things with your left hand?

(Percept-2)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

3. Lately, do you have more difficulty than you used to in seeing all of what you are looking at, or all of what is in front of you (in other words, are some areas of your vision less clear or less direct than others)?

(Percept-3)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

SCALE IV: HIGHER LEVEL COGNITIVE AND INTELLECTUAL FUNCTIONS

Instructions: Please answer these questions in the same way as the previous scales. Just put a check next to the response which most accurately describes the way you have been lately.

1. How often do your thoughts seem confused or illogical?

(CI-1)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

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2. How often do you become distracted from what you are doing or saying by insignificant things which at one time you would have been able to ignore?

(CI-2)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

3. How often do you become confused about (or make a mistake about) where you are?

(CI-3)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

4. How often do you have difficulty finding your way about?

(CI-4)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

5. Do you have more difficulty now than you used to in calculating or working with numbers (including managing finances, paying bills, etc.)?

(CI-5)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

6. Do you have more difficulty now than you used to in planning or organizing activities (i.e., deciding what to do and how it should be done)?

(CI-6)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

7. Do you have more difficulty now than you used to in solving problems that come up around the house, at your job, etc.? (In other words, when something new has to be accomplished, or some new difficulty comes up, do you have more trouble figuring out what should be done and how to do it?)

(CI-7)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

8. Do you have more difficulty now than you used to in following directions to get somewhere?

(CI-8)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

9. Do you have more difficulty now than you used to in following instructions concerning how to do things?

(CI-9)
( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

SCALE V: WORK

1. Do you presently hold a job?

( ) yes -- full time
( ) yes -- part time
( ) no (if relative is a student, go on to "E" below; otherwise go on to item "H" below)

2. If you hold a job, please indicate what kind of job it is and briefly describe the duties as best you can:

____

____

____

____

____

3. If you hold a job, please indicate the approximate salary:

____

4. If you hold a job, how much supervision is being given to you now?

( ) close observation and supervision in almost everything you do

( ) there is a supervisor around you most of the time, but supervision is not really constant

( ) receive only occasional supervision while working on a job, though there may be more supervision when a new job is given or after a job is completed

( ) usually receive supervision only when being given a new job to do, or after a job has been completed

( ) function very much on your own at work

( ) is self employed

5. Are you currently a student?

( ) yes -- full time
( ) yes -- part time
( ) no

6. If you are a student, are you currently taking regular academic courses or special education courses?

( ) all special education courses
( ) mostly special education courses
( ) about an equal number of each type of course
( ) all regular academic courses

7. If you are taking regular academic courses, what is your approximate grade point average now in these courses only (i.e., leaving out grades in special education courses)?

( ) better than 3.7 (A)
( ) 3.0 to 3.7 (B to A- minus)
( ) 2.0 to 2.9 (C to B- minus)
( ) 1.0 to 1.9 (D to C- minus)
( ) less than 1.0 (F)

8. What are the main family or home-related duties which you are performing at this time (include such things as planning family activities, disciplining children, managing finances, cooking, lawn care, shopping, etc. -- also indicate whether you perform these duties alone or with help from others)?

____

____

____

SCALE VI: RECREATION

1. What leisure time activities do you engage in at this time (include such things as hobbies, sports, reading, TV, clubs, attending church, etc.)?

2. What kinds of material have you been reading lately (include examples of specific books or magazines -- if you do not read at all, just indicate that)?

3. What T.V. programs have you been watching lately (if you do not watch T.V., just indicate that)?

4. What kinds of music have you been listening to lately?

SCALE VII: GENERAL

1. What are the activities that you need help with at this time?

2. **What are your major areas of difficulty at this time?**

RELATIVES ASSESSMENT OF PATIENT FUNCTIONING INVENTORY

____
Patient Name

____
Relative Name

____
Date

Relatives Assessment of Patient Functioning Inventory
Chelune, Heaton and Lehman

SCALE I: MEMORY

Instructions: Answer each of the questions by placing a check next to the response which most accurately describes your relative's recent behavior. As before, if you can think of any examples of the behavior described please write them on the back of the preceding page.

1. How often does your relative do or say something which indicates that he/she has forgotten something that has been told him/her within the last day or two?

   ☐ almost always
   ☐ very often
   ☐ fairly often
   ☐ once in a while
   ☐ very infrequently
   ☐ almost never

   Note: If this happens, is your relative aware of it?

   ☐ yes
   ☐ no
   ☐ I don't know

2. How often does your relative do or say something which indicates that he/she has forgotten something that was told him/her a year or more ago?

   ☐ almost always
   ☐ very often
   ☐ fairly often
   ☐ once in a while
   ☐ very infrequently
   ☐ almost never

   Note: If this happens, is your relative aware of it?

   ☐ yes
   ☐ no
   ☐ I don't know

3. How often does your relative do or say something which indicates that he/she has forgotten events which have occurred in the last day or two?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

4. How often does your relative do or say something which indicates that he/she has forgotten events which have occurred in the last day or two?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

5. How often does your relative do or say something which indicates that he/she has forgotten people whom he/she has met in the last day or two?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

6. How often does your relative do or say something which indicates that he/she has forgotten people whom he/she has met a year or more ago?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

7. How often does your relative lose track of time, or do things either earlier or later than they are usually done or are supposed to be done?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

8. How often does your relative fail to complete tasks he/she starts, apparently because he/she forgot that he/she was doing them? (Include such things as failing to put out cigarettes, turn off stove, etc.)

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

9. How often does your relative fail to complete tasks that he/she starts, apparently because he/she has forgotten how to do one or more aspects of them? (Here it would be especially helpful if you could give examples of the kinds of tasks your relative seems to have forgotten how to do.)

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

10. How often does your relative lose things or have trouble remembering where they are?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

11. How often does your relative forget things that he/she is suppose to do or has agreed to do (such as putting gas in the car, paying bills, taking care of errands, etc.)?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

SCALE II: LANGUAGE AND COMMUNICATION

Instructions: In each item just place a check next to the response which most accurately describes your relative's recent behavior. Again, if you can provide examples of the behavior described, these will be much appreciated. You should use the back of the preceding page for writing in examples.

1. How often does your relative have difficulties understanding what is said to him/her (for example, he/she may show lack of understanding by looking puzzled or asking for things to be repeated or explained)?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

   Note: If this happens, is your relative aware of it?

   ( ) yes
   ( ) no
   ( ) I don't know

Also, if this happens, what specific kinds of spoken information does your relative have difficulty understanding? (i.e., long words versus short words; complicated sentences versus simple sentences; information about specific events, people or things versus information about ideas, opinions or concepts; etc.)

____

____

____

____

____

____

____

____

2. How often does your relative fail to respond at all when something is said to him/her?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

3. How often does your relative have difficulty reading (i.e., identifying written or printed words)?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

   Note: If this happens, is your relative aware of it?

   ( ) yes
   ( ) no
   ( ) I don't know

   If your relative does not try to read at all, please indicate the reason for this:

   ____

   ____

4. How often does your relative have difficulty understanding what he/she reads?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

   Note: If this happens, is your relative aware of it?

   ( ) yes
   ( ) no
   ( ) I don't know

   Also, if this happens, what specific kinds of reading material does your relative have difficulty understanding?

   ____

5. Is it easier to demonstrate or show things to your relative than it is to tell him/her about them?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

6. When your relative speaks, are his/her words indistinct or improperly pronounced?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

Note: If this happens, is your relative aware of it?

   ( ) yes
   ( ) no
   ( ) I don't know

Also, if this happens, how often do you actually have difficulty understanding what words he/she is trying to say?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

7. How often does your relative have difficulty thinking of the names of things?

   ( ) almost always
   ( ) very often
   ( ) fairly often
   ( ) once in a while
   ( ) very infrequently
   ( ) almost never

Note: If this happens, is your relative aware of it?

   ( ) yes
   ( ) no
   ( ) I don't know

8. How often does your relative have difficulty thinking of the words for what he/she wants to say (i.e., other than names)?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

9. When your relative writes things, how often does he/she have difficulty forming the letters correctly?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

Also, if this happens, how often do you actually have difficulty understanding the words he/she has tried to write?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

If your relative does not write at all now, please indicate the reason for this:

____

____

____

10. When your relative writes things, how often does he/she have difficulty spelling, or make errors in spelling?

- ☐ almost always
- ☐ very often
- ☐ fairly often
- ☐ once in a while
- ☐ very infrequently
- ☐ almost never

Note: If this happens, is your relative aware of it?

- ☐ yes
- ☐ no
- ☐ I don't know

Also, if this happens, what specific kinds of words does he/she have difficulty spelling (are they long and complicated, short and simple, etc.)?

SCALE III: USE OF HANDS

Instructions: Please answer these questions in the same way as in the previous sections. As before, we would like you to use the back of the preceding page to write in any examples you can think of.

1. How often does your relative have difficulties performing tasks with his/her right hand (including such things as writing, dressing, carrying, lifting, sports, cooking, etc.)

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

Also, if this happens, what specific tasks does your relative have difficulty performing with the right hand?

____

____

2. How often does your relative have difficulties performing tasks with his/her left hand?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

Also, if this happens, what specific tasks does your relative have difficulty performing with the left hand?

____

____

SCALE IV: HIGHER LEVEL COGNITIVE AND INTELLECTUAL FUNCTIONS

Instructions: Please answer these questions in the same way as in the previous sections. Don't forget to give any examples you can think of, because these are very important.

1. How often do your relative's thoughts seem illogical or confused?

   - ☐ almost always
   - ☐ very often
   - ☐ fairly often
   - ☐ once in a while
   - ☐ very infrequently
   - ☐ almost never

   Note: If this happens, is your relative aware of it?

   - ☐ yes
   - ☐ no
   - ☐ I don't know

2. How often does your relative become distracted from what he/she is doing or saying by insignificant things which most people would ignore?

   - ☐ almost always
   - ☐ very often
   - ☐ fairly often
   - ☐ once in a while
   - ☐ very infrequently
   - ☐ almost never

   Note: If this happens, is your relative aware of it?

   - ☐ yes
   - ☐ no
   - ☐ I don't know

3. How often does your relative become confused about (or be in error about) where he/she is?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

Also, if this happens, please specify whether it occurs more in some places than in others (and give examples):

4. How often does your relative have difficulty finding his/her way about?

( ) almost always
( ) very often
( ) fairly often
( ) once in a while
( ) very infrequently
( ) almost never

Note: If this happens, is your relative aware of it?

( ) yes
( ) no
( ) I don't know

Also, if this happens, please give examples of the kinds of places where it tends to occur:

5. To what extent does your relative have difficulty calculating or working with figures (including managing finances, paying bills, etc.)?

( ) extreme difficulty - cannot do even the simplest calculations
( ) considerable difficulty even with simplest calculations
( ) does fairly well with simple calculations, but has much trouble with complicated ones
( ) has no trouble with simple calculations, but has some difficulty with complicated ones
( ) only seldom has any difficulty with calculations (even complicated ones)
( ) almost never has the slightest difficulty with even the most complicated calculations

Note: If your relative does have trouble in this area, is he/she aware of it?

( ) yes
( ) no
( ) I don't know

6. To what extent does your relative have difficulty in planning or organizing activities (i.e., deciding what to do, and how it should be done) for himself/herself and others?

( ) extreme difficulty - cannot plan or organize even routine activities without help from others

( ) considerable difficulty even with routine activities

( ) does fairly well with routine activities, but requires much help with anything new or complicated

( ) only seldom has any difficulty deciding on his/her own what to do, when to do it, and how it should be done (even in relation to new or complicated activities)

( ) almost never has the slightest difficulty - is extremely competent at planning and organizing even the most complicated activities

Note: If your relative does have trouble in this area, is he/she aware of it?

( ) yes
( ) no
( ) I don't know

7. Rate your relative's ability to deal effectively with problem situations that come up around the house, at his/her job, etc. (In other words, when something new has to be accomplished, or some new difficulty comes up, how well is your relative able to figure out what should be done and how to do it on his/her own?)

( ) extreme difficulty - cannot handle even the simplest problem on his/her own

( ) has considerable difficulty even with simple problems

( ) does fairly well solving simple problems, but has much difficulty (needs much help) solving new or complicated ones

( ) has no trouble handling simple problems on his/her own, but does have some difficulty (needs some help) solving new or complicated problems

( ) only seldom has any difficulty solving problems on his/her own (even new or complicated ones)

( ) almost never has the slightest difficulty solving even the most complicated and new problems on his/her own

Note: If your relative has trouble in this area, is he/she aware of it?

( ) yes
( ) no
( ) I don't know

8. To what extent does your relative have difficulty following directions to get somewhere?

( ) extreme difficulty - cannot follow even the simplest directions

( ) has considerable difficulty following even the simplest directions

( ) does fairly well with simple directions, but has much difficulty with complicated ones

( ) has no trouble with simple directions, but has some difficulty following complicated ones

( ) only seldom has any difficulty following directions ()even complicated ones)

( ) almost never has the slightest difficulty following even the most complicated directions to get somewhere

Note: If your relative has trouble in this area, is he/she aware of it?

( ) yes
( ) no
( ) I don't know

9. To what extent does your relative have difficulty following instructions concerning how to do things?

( ) extreme difficulty - cannot follow even the simplest instructions to do anything

( ) considerable difficulty carrying out even simple instructions

( ) does fairly well with simple instructiosn, but has some difficulty carrying out complicated ones

( ) has no trouble with simple instructions, but has some difficulty carrying out complicated ones

( ) only seldom has any difficulty carrying out instructions concerning how to do things (even complicated instructions)

( ) almost never has the slightest difficulty carrying out even the most complicated instructions

Note: If your relative has trouble in this area, is he/she aware of it?

( ) yes
( ) no
( ) I don't know

10. Compared to the way your relative was before his/her accident or present illness, how "bright" would you say that he/she is now? (For example, considering how well he/she can carry on an intelligent conversation, how clever his/her sense of humor is, and so forth.)

( ) a great deal worse than before - in this respect he/she is not at all the same person

( ) considerable worse now than before

( ) worse now than before

( ) only slightly worse now than before

( ) seems to be as bright as ever

( ) seems even brighter than before

Note: If your relative is not as bright now as he/she was before, is he/she aware of this?

( ) yes
( ) no
( ) I don't know

11. Please use this space to describe any difficulties your relative may be having in driving a car (if there are no difficulties, just say that, if he/she is not driving or cannot drive now please indicate the reason for this.

____

____

____

SCALE V: WORK

1. Is your relative presently holding a job?

   ( ) yes -- full time
   ( ) yes -- part time
   ( ) no (if relative is a student, go on to "E" below; otherwise go on to item "H" below)

2. If your relative is holding a job, please indicate what kind of job it is and briefly describe the duties as best you can:

____

____

____

____

____

3. If your relative is holding a job, please indicate the approximate salary (if you have no idea, just indicate that):

____

4. If your relative is holding a job, how much supervision is being given to him/her now?

   ( ) is closely observed and supervised in almost everything he/she does

   ( ) there is a supervisor around him/her most of the time, but supervision is not really constant

   ( ) receives only occasional supervision while working on a job, though there may be more supervision when a new job is given or after a job is completed

   ( ) functions very much on his/her own at work

   ( ) is self employed

5. Is your relative currently a student?

   ( ) yes -- full time
   ( ) yes -- part time
   ( ) no

6. If your relative is a student, is he/she currently taking regular academic courses or special education courses?

   ( ) all special education courses
   ( ) mostly special education courses
   ( ) about an equal number of each type of course
   ( ) all regular academic courses

7. If your relative is taking regular academic courses, what is his/her approximate grade point average now in these courses only (i.e., leaving out grades in special education courses)?

   ( ) better than 3.7 (A)
   ( ) 3.0 to 3.7 (B to A- minus)
   ( ) 2.0 to 2.9 (C to B- minus)
   ( ) 1.0 to 1.9 (D to C- minus)
   ( ) less than 1.0 (F)

8. What are the main family or home-related duties which your relative is performing at this time (include such things as planning family activities, disciplining children, managing finances, cooking, lawn care, shopping, etc. -- also indicate whether the relative performs these duties alone or with help from others)?

____

____

____

____

____

____

____

____

____

SCALE VI: RECREATION

1. What leisure time activities does your relative engage in at this time (include such things as hobbies, sports, reading, TV, clubs, attending church, etc.)?

2. What kinds of material is your relative reading lately (include examples of specific books or magazines -- if he/she does not read at all, just indicate that)?

3. What T.V. programs does your relative watch lately (if he/she does not watch T.V., just indicate that)?

4. What kinds of music does your relative listen to lately?

SCALE VII: GENERAL

1. What are the activities that your relative needs help with at this time?

2. What do you think are your relative's major areas of difficulty at this time?

PSYCHOMETRIC ASSESSMENT MANUAL

NAME: ____________________ DATE: ________________ EXAMINER: ________________

OBSERVATIONS OF TEST BEHAVIOR (CONTEXT)

AFFECT:

APPEARANCE:

COOPERATION (general/specific):

MOTIVATION (general/specific):

APPROACH TO TEST TASKS:

ORGANIZATION OF WORK:

LEVEL OF ANXIETY (general/specific):

VERBALIZATIONS:

TOLERANCE FOR FRUSTRATION (general/specific):

CONCERN WITH "Doing it Right" (requests for feedback, obsessiveness):

ERASURES, CORRECTIONS:

INCOMPLETIONS, " Don't Know" RESPONSES:

RESPONSE TO OBVIOUS FAILURES:

RAPPORT:

OTHER:

DATA SHEET

NAME: ________ AGE: ____ BIRTH DATE: ________

SS# ________ DATE TESTED: ________

S-R	Raw	Standard	T-score
Verbal IQ			
Performance IQ			
Full Scale IQ			
Information			
Digit Span			
Vocabulary			
Arithmetic			

	Raw	Standard	T-Score
Comprehension			
Similarities			
Picture Completion			
Picture Arrangement			
Block Design			
Object Assembly			
Digit Symbol (Coding)			

WRAT-R	Raw	Standard	Percentile
Reading (Recognition)			
Spelling			
Arithmetic			
Nelson-Denny			
Vocabulary			
Reading Comprehension			
Reading Rate			
Woodcock			
Word Identification			
Word Attack			
Word Comprehension			
Passage Comprehension			
TOWL-2			
Thematic Maturity			
Contextual Vocabulary			
Syntactic Maturity			
Contextual Spelling			
Contextual Style			

ler

Reading Level ____ Mental Age ____

Reading Age ____ Reading Quotient ____

Nonspecific ____ Dysphonetic ____

Dyseidetic ____ Mixed ____

	Raw	Standard	Percentile
Aphasia Screening Test			
BDAE			
Confrontation			
Responsive			
High Phrases			
Low Phrases			
Fluency			
Animals			
FAS			
Oral Comprehension			
Auditory			
Speech Sounds			
Rhythm			

WMS-R			
Verbal Memory			
Visual Memory			
General Memory			
Attention/Concentration			
Delayed Recall			

LT

List A Trial 1 ____ List B ____

List A Trial 5 ____ Short Delay Free Recall ____

List A Total ____ Short Delay Cued Recall ____

IMPERCEPTIONS	Left	Right
Tactile Errors R		
Auditory Errors R		
Visual Errors R		
Tactile Finger Rec. R		
Finger Tip # Writing R		

	Raw	Standard	T-Score
Tactile Form Rec. R			
Tactile form Rec. L			
Total Imperception R			
Total Imperception L			
Total R and L			
TACTILE/KINESTHETIC			
TPT Dominant Time			
TPT Non-Dominant Time			
TPT Both Time			
TPT Total Time			
TPT MEMORY			
TPT LOCLIZATION			
MOTOR			
Tapping Dom. (R)			
Tapping N-Dom. (L)			
Grooved Pegboard (R)			
Grooved Pegboard (L)			
Star Dom. (1x)			
Star N-Dom. (1x)			
Grip Dom.			
Grip N. Dom.			
Categories			
Trails A (1x)			
Trails B (x)			

Hooper		
Benton Judgment of Line		
Benton Visual Retention		
Benton Visual Form Recognition		
Raven SPM		
Smiths SDT		

Stroop Color-Word		
Word		
Color		
Color-Word		
Interference		

PASAT	
Series 1	
Series 2	
Series 3	
Series 4	

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
PRAS INTERIM SUMMARY
Initial Vocational Assessment Results

NAME: ____________________ WPIC#: ____________ REFERRAL DATE: ________
REFERRAL SOURCE: ________ NAME: __________ DATE OF INITIAL SESSION: ________
PRAS CLINICIAN: ________________ DATE OF NIS SUBMISSION: ________
[NOTE: Standard Score (x=100, SD=15)]

WIDE RANGE ACHIEVEMENT TEST - REVISED, LEVEL 2

DATE: ______

	Standard Score	Percentile	Rating
Reading Recognition			
Spelling			
Arithmetic			

GATES-MACGINITIE READING TEST

DATE: ______

	Standard Score	Percentile	Rating
Vocabulary			
Comprehension			

NELSON DENNY READING TEST

DATE: ______

	Percentile	Rating
Vocabulary		
Comprehension		

STRONG CAMPBELL INTEREST INVENTORY,
INTEREST IN GENERAL OCCUPATIONAL THEMES:

DATE: ______

Realistic		Social	
Investigative		Enterprising	
Artistic		Conventional	

CAREER OCCUPATIONAL PREFERENCE SYSTEM INTEREST INVENTORY - PROFESSIONAL LEVEL

DATE: ______

SCIENCE Medical-Life	___%	TECHNOLOGY Civil	___%	BUSINESS Management	___%	ARTS Performing	___%
SCIENCE Physical	___%	OUTDOOR Nature	___%	COMPUTATION	___%	ARTS Design	___%
TECHNOLOGY Electrical	___%	OUTDOOR Agribusiness	___%	COMMUNICATION Written	___%	SERVICE Instructional	___%
TECHNOLOGY Mechanical	___%	BUSINESS Finance	___%	COMMUNICATION Oral	___%	SERVICE Social	___%

CAREER ABILITY PLACEMENT SURVEY

1504

DATE: ______

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	Stanine	Percentage		Stanine	Percentage
Mechanical Reasoning		%	Language Usage		%
Spatial Relations		%	Word Knowledge		%
Verbal Reasoning		%	Perceptual Speed & Accuracy		%
Numerical Ability		%	Manual Speed & Dexterity		%

WESCHLER ADULT INTELLIGENT SCALE - REVISED (WAIS-R)

DATE: ______

	Standard Score	Range
Verbal IQ	________	____
Performance IQ	________	____
Full Scale IQ	________	____

Verbal Subtests	Scaled Score	*Performance Subtests*	Scaled Score
Information	________	Picture Completion	________
Digit Span	________	Picture Arrangement	________
Vocabulary	________	Block Design	________
Arithmetic	________	Object Assembly	________
Comprehension	________	Digit Symbol	________
Similarities	________		

Mean = 10, Standard Deviation = 3

MULTIDIMENSION SELF-ESTEEM INVENTORY

	Percentile	Rating		Percentile	Rating
Global Self-Esteem	______	____	Moral Self-approval	______	____
Competence	______	____	Body Appearance	______	____
Lovability	______	____	Body Functioning	______	____
Likability	______	____	Identity Integration	______	____
Personal Power	______	____	Defensive	______	____
Self-Control	______	____	Self-Enhancement	______	____

COMMENTS: ____
____
____

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COMPREHENSIVE VOCATIONAL ASSESSMENT

FUNCTIONAL AREA		INSTRUMENT/TEST	ADMINISTRATION
Vocational Aptitude/ Abilities		Career Ability Placement Survey	60 minutes
Career Interests		Career Occupational Preference Survey	30 minutes
	or		
		Strong-Campbell Interest Inventory	30 minutes
Personal, Environmental and Work Role Preferences		Career Occupational Preference System Inventory	30 minutes
	or		
		Myers-Briggs Type Indicator	30 minutes
Reading Comprehension		Gates-MacGinitie	40 minutes
	or		
		Nelson Denny	25 minutes
Academic Achievement (Reading Recognition, Arithmetic, Spelling)		Wide Range Achievement Test-Revised	35 minutes
Intelligence/ Scholastic Aptitude		Weschler Adult Intelligence Scale-Revised	90 minutes
Educational/ Employment Histories		Clinical Interview	60 minutes
Review of formal/ informal assessment		Clinical Interview	60 minutes

Minimum Total Time = 6.5 hours

VOCATIONAL ASSESSMENT FORMAT

The categories below are used in gathering information relevant to rehabilitation of the psychiatrically disabled individual. Information in each of the categories is obtained as it relates specifically to issues in vocational/educational/social rehabilitation as part of the assessment process. These are guidelines only.

1. Psychological/Psychiatric

Diagnosis
Onset
Institutionalizations (frequency, duration; voluntary or involuntary)
Forensic evaluation (charges pending; legal obligations)
Self-description (feelings about self; self-statements; perceived strengths and weaknesses)
Medication (type and effects; degree of compliance)
Interpersonal skills (feelings regarding others; ability to get along; difficulties in relationships; one-to-one vs. group interaction)
Problem behaviors (frequency, duration, intensity, etc.)
Attitudes regarding therapy (previous exposure; motivation)
Problem identification (insight; objectivity; motivation)
Appearance (grooming and hygiene)

2. Medical

Disability
How and when disabled
Functional limitations (work activities possible; tolerance for work activities; patient concerns regarding limitations as related to work)
Medication (type and effects)
Current diagnosis (attending physician; currently being treated; release for work)
Prognosis
Financial coverage

3. Social and Environmental

Current activities (special interests, leisure activities; involvement in community affairs, social and recreational activities)
Living arrangement
Marriage and family (feelings about family, marital compatibility, family attitudes toward rehabilitation)
Child care
Geographic preferance
Support systems (family, knowledge of community agencies)
Relevant early history (parental employment; guidance and discipline)
Economic conditions (sources of income, financial resources, dependents, financial obligations; DPA-SSI-SSDI-IC eligibility; insurance)
Transportation (own car, ability to use public transportation, proximity to public transportation)

Educational

Elementary, High School, College (best/worst subjects; relationship with teachers, students; extracurricular activities; special achievements; toughest problems; how education financed; reasons for choosing major field)
G.E.D. (reasons for leaving school)
Specialized training, on-the-job training (what, when, where)
Recent courses (relationship to career goals; interest in future training)

Vocational

Work history (includes: list of jobs; likes, dislikes; strengths, problems; interpersonal - supervisors and co-workers)
Military assignments (branch; type of duty; discharge)
Previous OVR exposure
Terminations (employer reasons; patient reactions)
Unemployment (periods; reasons for job changes)
Vocational goal (primary and secondary; related experience; necessary training or experience; necessary skills and licenses; salary expectations)
Job seeking skills (ability to explain/describe: 1. major assets; 2. vocational liabilities; 3. disability; 4. employment gaps; 5. patterns, methods and frequency of job search; 6. appearance and grooming; 7. financial resources)

Testing

Intellectual, achievement, interest and aptitude tests are administered routinely, for example:

Wechsler Adult Intelligence Scale-Revised
Wide Range Achievement Test-Revised
Gates-MacGinitie Reading Comprehension Test
Strong Campbell Interest Inventory
Self-Directed Search, COPS, COPS-P

CAPS

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Assessment Instruments (Vocational Rehabilitation Test File)

The following is a partial list of instruments and tests utilized in the assessment process. The selection of particular evaluation instruments is dependent upon the nature of the patient's problem and the kinds of data needed in order to thoroughly assess needs, deficits, and strengths for any particular patient referral. In addition, neuropsychological, intellectual, and personality evaluation is available,

Aptitude

Multidimensional Aptitude Test Battery
Bennett Mechanical Comprehension Test
Career Ability Placement Survey (CAPS)
Differential Aptitude Test Battery (DAT)
General Aptitude Test Battery (GATB)
General Clerical Test
Oral Directions Test (Industrial)
Minnesota Clerical Test
Revised Minnesota Paper Form Board
SRA Pictorial Reasoning Test
Computer Aptitude, Literacy, and Interest Profile (CALIP)
General Clerical Test

Achievement/Educational

College Qualification Test
Industrial Reading Test
Wide Range Achievement Test-Revised
Stanford Achievement Test Series
California Achievement Test

Perceptual-Motor

Bender Gestalt Test
Benton Visual Retention Test
Crawford Small Parts Dexterity Test
Memory for Design Test
Minnesota Rate of Manipulation Test
Purdue Pegboard
Purdue Perceptual Motor Survey
Lincoln Oseretsky Motor Development Scale
Southern California Sensory Integration Tests
Frostig Developmental Test of Visual Perception
Woodcock, Fristoe and Goldman Test of Auditory Discrimination
Jordan Left-Right Reversal Test
Plus many others

Interest

AAMD-Becker Reading Free Vocational Interest Inventory (RFVII)
California Occupational Preference System Interest Inventory (COPS)
California Occupational Preference System Interest Inventory-Professional Level (COPS-P)
Minnesota Vocational Interest Inventory
Wide Range Interest-Opinion Test (WRIOT)
Interest Checklist (USES)
Self-Directed Search
Strong Vocational Interest Inventory

Counseling/Personality

Millon Clinical Multiaxial Inventory (MCMI)
Edwards Personal Preference Schedule
Career Orientation Placement and Evaluation Survey (COPES)
Minnesota Multiphasic Personality Inventory
Mooney Problem Checklist
Rotter Incomplete Sentences Blank
16 Personality Factor Test
Survey of Personal Values
Career Maturity Index
Career Decision-Making System
Multidimensional Self Esteem Inventory (MSEI)
Myers-Briggs Type Indicator

Educational

Adult Basic Learning Examination
Detroit Tests of Learning Aptitude
Spache Diagnostic Reading Scales
Stanford Diagnostic Reading Test Series
Stanford Diagnostic Math Test Series
Woodcock Reading Mastery Test
Gates-MacGinitie Reading Test
Stanford Test of Academic Skills
Nelson-Denny Reading Test

PSYCHOMETRIC APPROACHES TO ASSESSMENT

The tests described and demonstrated in the videotape are listed below. ·The videotape used to supplement this training contains simulated demonstrations from actual psychological tests. The items, forms, and materials included are the property of the test authors and publishers and should not be duplicated. The test items should be treated as privileged information and not be discussed with non-professionals.

Intelligence and Achievement Tests

WECHSLER ADULT INTELLIGENCE SCALE-REVISED (WAIS-R). The WAIS-R is an individually administered intelligence test consisting of 11 different subtests: 6 verbal subtests and 5 performance subtests. The WAIS-R usually takes 60 to 75 minutes to administer. Administration and scoring procedures are highly standardized, with detailed instruction provided in the test manual. The 11 WAIS-R subtests include: (Verbal) Information, Comprehension, Arithmetic, Vocabulary, Digit Span, and Similarities; (Performance) Picture Completion, Picture Arrangement, Block Design, Object Assembly, and Digit Symbol.
David Wechsler

PEABODY PICTURE VOCABULARY TEST (PPVT). This test is an individually administered, norm-referenced test of hearing vocabulary available in two parallel forms (L and M). Both forms are comprised of five sample items followed by 175 test items arranged in order of increasing difficulty. The subject's task is to select the picture considered to illustrate best the meaning of a stimulus word presented orally by the examiner.
Lloyd Dunn & Leota Dunn

WIDE RANGE ACHIEVEMENT TEST-REVISED (WRAT-R). The WRAT-R is a standardized measure of academic abilities. The test measures reading word recognition, written spelling, and arithmetic computation. The three subtests are easily administered and scored, usually in less than 30 minutes. The test yields three raw scores: one for each subtest, reflecting the total number of items completed correctly. Raw scores are converted into grade equivalents, percentiles, and standard scores, using the norm tables provided in the manual. Norms are available from age 5 years 5 months to age 64. Advantages of the WRAT include its ease of administration and scoring, its wide acceptance both in education and psychology, and its large normative sample.
J. Jastak & S. Jastak

PEABODY INDIVIDUAL ACHIEVEMENT TEST. A wide-range screening measure of achievement in the areas of mathematics, reading, spelling and general information. The battery is untimed but generally takes 40 minutes to administer. Scores are presented as grade and age equivalents, percentile ranks and standard scores.
L. Dunn & F.C. Markwardt

WOODCOCK-JOHNSON PSYCHOEDUCATIONAL BATTERY. A comprehensive measure of the cognitive ability and achievement of individuals ranging from preschool level to adult. The battery is composed of 27 subtests including Reasoning, Perceptual Speed, Mathematics and Written Language. Administration time is typically 2 to 2 1/2 hours.
R. Woodcock & M. Johnson

GATES-MACGINITIE READING TESTS. This test is a multiple-choice paper-and-pencil test used to assess basic reading skills. The test has a vocabulary section and a reading comprehension section in which the subject reads short paragraphs and answers written questions about the paragraphs. Both sections are timed, with 20 minutes allowed for the vocabulary section and 35 minutes for the reading comprehension section. The reading comprehension test is advantageous in that it appears to tap reading skills required in everyday usage.
Walter H. MacGinitie

GRAY ORAL READING TESTS-REVISED. From grades one to college level, the GORT-R has two forms (4 on 1967 GORT), with each form containing thirteen reading selections or passages. The tests are designed to assess oral reading and to aid in diagnosing reading difficulties.
J.L. Wiederholt & B.R. Bryant

WOODCOCK READING MASTERY TESTS. Composed of five individually administered reading tests for use from grades K to 12, measuring Letter Identification, Word Identification, Word Attack, Word Comprehension and Passage Comprehension.
R. Woodcock

MONROE-SHERMAN READING APTITUDE AND ACHIEVEMENT TESTS. Is a group or individually administered series of tests assessing paragraph understanding, spelling, word discrimination, and arithmetic computation. Scores are presented as grade equivalents.
M. Monroe & E. Sherman

Personality Tests

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY (MMPI). This 566-item true and false questionnaire has been a widely used clinical and research tool. Test results are presented as a profile of validity and clinical scales. Abbreviated versions of the MMPI are also available.
Starke R. Hathaway & J. Charnley McKinley

MILLON CLINICAL MULTIAXIAL INVENTORY (MCMI). The MCMI is an objective personality test. Subjects answer true/false questions; interpretations of the resultant profile focus on personality characteristics and psychopathology.
Theodore Millon

SIXTEEN PERSONALITY FACTOR QUESTIONNAIRE (16PF). This is a self report inventory assessing personality on sixteen dimensions or scales. A variety of test forms are available.
Raymond Cattell

THEMATIC APPERCEPTION TEST (TAT). The TAT consists of vague black and white pictures which the subject is asked to use to generate associated stories. The TAT is one of the most widely used story telling projective tests for adults.
Henry A. Murray

RORSCHACH TEST. The Rorschach test is probably the best known of the projective techniques. The subject is shown each ink blot one at a time and is asked to report what the blot reminds him of. A number of scoring systems are available based on major response variables such as number of responses, color and shading, and the verbatim content of the response.
Hermann Rorschach

Neuropsychological Batteries

HALSTEAD-REITAN NEUROPSYCHOLOGICAL TEST BATTERY

The Halstead-Reitan Neuropsychological Test Battery (HRNTB) consists of a number of individual tests which, when administered together, comprise a battery. The Halstead-Reitan measures large samples of behavior in a number of areas associated with brain function: motor, sensory, visual-spatial, language, memory, auditory-perceptual, and higher level conceptual abilities. Each test may measure a variety of functions which may not be clearly defined. For example, the Speech Sounds Perception Test is a measure of the ability to hear speech sounds and match sounds into their written equivalent, as well as attend for an extended period of time. Errors may result from deficits in any or all of these areas, thus a great deal of clinical judgment is required in the interpretation of results. The battery tends to be a "right hemisphere" oriented battery in that much of the focus is on nonlinguistic, visual-spatial, and sensory/kinesthetic tasks.

The battery was originally developed by Ward Halstead at the University of Chicago in 1935. Halstead began by attempting to develop a test battery to measure "biological intelligence." He performed extensive formal and informal studies on brain damaged individuals, culminating in the introduction of various tests able to measure brain dysfunction. Halstead's original battery consisted of 13 tests, designed to reflect brain impairment. Halstead also developed the Impairment Index, a method of detecting brain impairment by using a combination of psychological test results.

Ralph Reitan, a graduate student of Halstead, made additions and improvements to the battery, and performed studies which clearly documented the validity of the battery in the discrimination of brain damaged and normal individuals.

There are three forms of the Halstead-Reitan battery: the HRNTB for Adults (age 15 and above), the Halstead Neuropsychological Battery for Children (age 9-14), and the Reitan-Indiana Neuropsychological Test Battery for Children (age 5-8). Administration of the battery usually takes between five and eight hours with individual tests ranging from 10 minutes to one hour or more. It involves interactive testing between examiner and subject. The test is tiring and frustrating for subjects, particularly those with significant brain impairment. Because of the amount of time necessary and the sophisticated apparatus required, the Halstead-Reitan is a costly battery to administer.

The Halstead-Reitan Neuropsychological Test Battery is the most widely researched neuropsychological test battery; thus, extensive validity data is available on the identification, lateralization and localization of brain dysfunction. Numerous cross-validations have upheld Reitan's original validity studies. Reliability of the Halstead-Reitan has been less rigorously evaluated. In general, reliability appears good. Test-retest reliability of the individual tests ranges from .59 (TPT localization) to .87 (Trail Making Test, Part B).

This battery of tests includes the original neuropsychological tests developed by Ward Halstead and the modifications and additions of Ralph Reitan. The battery is comprised of the following tests.

CATEGORIES TEST. A test of abstracting ability. Stimulus figures, which vary in size, location, shape, number, color and intensity, and are grouped by abstract principles, are projected on a screen. The task of the subject is to figure out the principle relating stimulus subtests and signal the answer by pressing the appropriate key on a board. The test is an excellent discriminator between brain damaged and neurologically intact groups. The test measures the ability to sustain attention, remember past performance, evaluate past performance and learn from feedback, concentrate, analyze visually presented material, understand spatial relationships, and demonstrate cognitive flexibility in handling a complex, changing problem.

TACTUAL PERFORMANCE TEST. The Tactual Performance Test (TPT) uses a modification of the Seguin-Goddard form board. The subject is blindfolded and is not permitted to see the stimulus material. The task is to fit blocks into the proper spaces on the board using first the preferred hand, then the nonpreferred hand, then both hands. Times are recorded for each trial and also for the total time required for all three trials. The stimulus materials are then put away and the blindfold is removed. The subject is then asked to draw a diagram of the board representing the blocks in their proper spaces. The drawing is based upon the number of blocks correctly reproduced (Memory) and the number correctly placed (Localization). The test requires the ability to recognize forms tactually, perform coordinated movements of the hands and arms, perceive their own movement in space without visual cues, and plan and solve nonverbal kinesthetic problems. Performance of the right and left sides of the body is evaluated on the TPT. The Memory and Localization components require both spatial and incidental memory. The test is sensitive to brain damage and is more likely to discriminate schizophrenics from organics than the Categories test. The Localization score is particularly sensitive to organicity and tends to be much less affected by schizophrenia than other measures with similar levels of sensitivity.

RHYTHM TEST. The Rhythm Test is a subtest of the Seashore Test of Musical Talent. The subject must discriminate between 30 pairs of rhythmic beats which are sometimes the same and sometimes different. The task measures alertness to nonverbal auditory stimuli, sustained attention to the task, and the ability to perceive and compare different rhythmic sequences. Because of the attentional component, the Rhythm test is not felt to be an effective discriminator between functional psychiatric disorders and organicity.

SPEECH SOUNDS PERCEPTION TEST. The Speech Sounds test consists of 60 spoken nonsense syllables, the beginning and ending consonant sounds of which vary while their "ee" vowel sound remains constant. The subject must underline the spoken syllable, selecting from four alternatives printed on the test form. The test requires attention, auditory perception of verbal material, and the ability to match phonemes with their written equivalents (graphemes).

FINGER OSCILLATION TEST. Finger tapping is a measure of fine motor speed which uses a mounted tapper equipped with a counter. The subject is administered several consecutive trials to each hand until attaining a criteria of five trials within a five-point range of each other. The score for the dominant hand and the nondominant hand is the average of the five trials. Fine motor speed,coordination and left-right body comparisons are assessed. Because of the focus on basic (versus complex) neuropsychological functions, schizophrenics are less likely to show impairment similar to that found in organics.

TRAIL MAKING TEST. This test consists of two parts, Trails A and Trails B. Trails A consists of 25 circles distributed randomly over a sheet of paper and numbered from 1 to 25. The subject is required to connect the circles with a pencil line in ascending numerical order. Part B also consists of 25 circles, these numbered from 1 to 13 and lettered from A to L. The task is to connect the circles in sequence, alternating between numbers and letters. The scores obtained are the time taken to complete each task and the number of errors. The test measures visual-motor tracking skills, counting ability, spatial skills, sequential and planning ability, cognitive flexibility in shifting between letter and number sets, and the ability to handle verbal material. The test, Trails B in particular, is a sensitive indicator of brain dysfunction. The test is particularly difficult for schizophrenics because of hypothesized motivational difficulties (they fail to complete the test). In a study using the Trail Making Test with a psychiatric population, when motivational and emotional factors were qualified, the discriminative ability to the test was enhanced.

STRENGTH OF GRIP TEST. A plunger type dynamometer with a grip adjustable for hand size is used to measure strength. Trials alternating between the dominant and nondominant hand are administered with the score being the average between two trials for each hand. The test measures grip strength as well as providing a comparison of the right and left sides of the body.

LATERAL DOMINANCE EXAMINATION. The subject is required to perform a number of tasks with their hands and feet in order to determine preference regarding handedness and footedness. Items include such tasks as name writing, pretended throwing movements and pretended kicking. This test is given relatively early in the battery in order to determine the order of administration of dominant-nondominant subtests on subsequent tests in the battery.

SENSORY-PERCEPTUAL EXAMINATION. This test measures tactile, auditory, and visual perceptual abilities. The procedures require the subject to perceive unilaterally presented stimuli on each side of the body. Next, stimuli are presented in a bilateral, simultaneous manner to determine the subject's ability to perceive both stimuli. Tactile, visual, and auditory sensitivity are measured, as well as left-right comparisons.

TACTILE FINGER LOCALIZATION. Light tactile stimuli (finger touch) are presented to each finger of the dominant and nondominant hand while the subject's eyes are closed. The subject identifies which finger is touched, using a predetermined numbering system. Each finger on each hand is touched four times and the number of errors are recorded. Tactile perception and right-left comparisons are measured.

FINGERTIP NUMBER WRITING PERCEPTION. The numbers 3,4,5, or 6 are traced on the subject's fingertips. With eyes closed, the subject must identify the numbers presented four times to each hand in a predetermined order. The score is the number of errors. The test provides a measure of graphesthesia and left-right comparisons.

TACTILE FORM RECOGNITION. The subject places one hand through a hole in a board and a plastic chip in one of four forms (circle, cross, square, or triangle) is placed on their fingertips. Without seeing the chip, the subject must point to the corresponding chip displayed on the board. Each of the four chips are presented twice to each hand. The score is the total errors and response time for each hand. The test measures stereognostic abilities and left-right comparisons.

MODIFIED HALSTEAD-WEPMAN APHASIA SCREENING TEST. This procedure provides a measure of several aspects of language ability and usage, including the ability to name common objects, spell, read, identify numbers and letters, write, do arithmetic calculations, articulate, identify body parts, perform pretended movements, understand the meaning of spoken language, follow directions, and differentiate left from right. It also tests visual constructional abilities (drawing) and provides samples of the subject's attempts at reproducing the spatial configuration of several forms.

In addition to the above noted tests, the Wechsler Adult Intelligence Scale-Revised (WAIS-R) and the Wide Range Achievement Test-R (WRAT-R) are administered as part of the Halstead-Reitan Neuropsychological Test Battery.

INTERPRETATION OF THE HALSTEAD-REITAN NEUROPSYCHOLOGICAL TEST BATTERY

Results of the Halstead-Reitan Neuropsychological Test Battery are interpreted on a number of levels. The most basic level is to determine whether each single test score falls within a normal or impaired range. This is done through comparison with single cut-off criterion scores established by Reitan. In addition to interpretation of single tests, the Impairment Index, originally designed by Halstead, reflects overall performance on the battery of tests. The Impairment Index is calculated as the number of tests falling within the impaired range divided by the total number of tests. For the Halsted-Reitan Neuropsychological Test Battery, these seven tests are used in the calculation of the Impairment Index: The Rhythm Test, Speech Sounds Perception Test, dominant hand Finger Oscillation, Category Test, Tactual Performance Test total time, Memory, and Location. The minimum Impairment Index score reflecting no impairment, is 0.0--none of the tests within an impaired range. A maximum score of 1.0 on the Impairment Index indicated that all scores are within the brain damaged range. Reitan suggests that Impairment Index scores above 0.45 are considered indicative of brain damage.

Another method of interpretation of raw Halstead-Reitan scores was introduced by Russell, Neuringer, and Goldstein in 1970. Instead of using a single cut-off score, this system rates each test on a six-point scale (0 - 5). In addition to providing a uniform coding system, the Russell et al. classification adds to Reitan's method of scoring results in that this system allows for severity of impairment rather than tallying the number of tests within the impaired range. Ratings range from 0 (above average) and 1 (no impairment) to 5 (very severe impairment). Ratings of 2, 3, and 4 reflect mild, moderate, and severely impaired levels of performance. Ratings of 2 or more are equivalent to being past the cut-off score for presence of brain dysfunction as established by Reitan's initial validation study.

An Average Impairment Rating is also calculated in the Russell, Neuringer, and Goldstein system. It represents the average of individual test ratings. An Average Impairment Rating of above 1.65 is considered to be indication of the presence of brain dysfunction. To illustrate the advantages of the Russell et al. system, consider two individual subjects obtaining a Halstead Impairment Index of 1.0. Both fall at the maximum level of brain dysfunction possible using the Reitan Impairment Index. However, when converting these same raw scores using the Russell et al. system, it would be possible for the Average Impairment Index to reflect significant performance differences; for example, 2.0 in one subject and 4.5 in another. While the interpretation for the first subject is one of mild, generalized impairment (all scores within a mildly impaired range), subject 2's performance reflects severe, global impairment of brain functions. Thus, this alternative scoring system is able to incorporate broader images of performance, both for clinical and research purposes.

STRENGTHS AND WEAKNESSES OF THE HALSTEAD-REITAN NEUROPSYCHOLOGICAL TEST BATTERY

Advantages of the HRNTB include its ability to measure a wide variety of brain functions in a highly standardized fashion. The Halstead-Reitan is the most widely researched neuropsychological test battery, thus extensive validation is available. The battery provides for the collection of research data which is objective and standardized. Finally, interpretation and inferences drawn from the Halstead-Reitan allow for the identification of test patterns and relationships, empirically typed to the many variants of brain dysfunction.

The major disadvantage of the Halstead-Reitan Neuropsychological Test Battery is its cost, both in terms of its time of administration and cost of administration and material. Time of administration for the entire battery is approximately six hours, which presents a significant limitation when testing impaired patients. Cost of materials for the Halstead-Reitan exceeds $1,300 and the average cost of a single administration of the battery ranges between $200 and $500.

Other disadvantages include the dependence on motor skills and the failure of the battery to address significant areas of possible neuropsychological deficit, including memory functions and language skills. A final weakness is its failure to effectively discriminate between schizophrenic and brain damaged populations.

Excerpted from M. McCue, Assessment services in psychiatric rehabilitation. In L. Katz & M. McCue (Eds.), Psychiatric rehabilitation: A handbook for practitioners. St. Louis: Warren Green, (in press).

THE LURIA-NEBRASKA NEUROPSYCHOLOGICAL BATTERY

The Luria-Nebraska Neuropsychological Battery (LNNB) is a test battery which is composed of 269 individual items based upon the neuropsychological test procedures developed by the Russian psychologist, A.R. Luria. In his extensive study of the functions of the brain, Luria developed procedures which he reported could localize disorders of the brain and, because of the specificity of his test items, could contribute valuable information to the planning of rehabilitation treatment. Luria's approach is termed a "qualitative" approach to neuropsychological examination in that the procedure is guided by clinical insight into a particular patient's performance. Tests are administered in a flexible fashion, focusing upon areas of deficit and bypassing areas judged to be intact. Clinical interpretation, rather than comparison with standard normative information, was used by Luria to infer the presence of brain damage and to make specific recommendations for treatment. While Luria was quite effective in using this approach to neuropsychological evaluation, several limitations arise in applying Luria's tests in the United States. The lack of any standardized manner for test administration, standardized materials, normative data for interpretative comparison, or data on the reliability and validity of procedures present significant obstacles to the use of these procedures.

Acknowledging the potential value of Luria's tests in the diagnosis and treatment of brain disorders, Golden and his colleagues undertook a standardization of these tests, which were originally translated from Russian into English by Anne-Lise Christiensen. Golden developed standardized administration procedures and materials for Luria's tests, as well as scoring procedures to allow for quantitative analysis of results and comparisons with normative populations. Original validity studies suggested that the comprehensive Luria-Nebraska Neuropsychological Battery could validly discriminate between persons with and without brain damage.

At the current time, only one form of the Luria-Nebraska Neuropsychological Battery is available, for individuals ages 15 and up although Golden states that the battery has been used effectively with individuals as young as age 12. A version of the LNNB for children and a second version of the adult tests (LNNB Form II) are currently available.

The Luria-Nebraska Neuropsychological Battery is made up of 269 different items, most of which differ in some aspect from other items in the battery. The items make up 52 separate but not totally independent scales: 14 clinical scales, 8 localization scales, and 30 factor scales.

Test items are of varying complexity and degree of difficulty but, in general, each requires only a very short, limited response. Items also vary as to the mode of stimulus input and response output. For example, items might be presented to subjects orally, by written verbal directives, by visually presented designs, or tactually. Subjects also respond by different means including aurally, motorically, or by writing. Some tasks are speeded while others have no time limits.

The 269 items are divided into 11 clinical scales, derived from Luria's basic classification of his own items into broad categories. Each scale represents a complex area of neuropsychological functioning, including motor, rhythm, tactile, visual, receptive speech, expressive speech, writing, reading, arithmetic, memory, and intellectual functions. The following is a more detailed description of the LNNB scales.

MOTOR FUNCTIONS. This scale investigates a number of simple and complex motor functions. The first 4 items deal with simple, rapid movements of the fingers and hands. These tasks are timed and performed with both the left and right hands. The next set of items (4) deals with the ability to use tactile feedback to guide motor activity. The subject's hands and fingers are placed in certain positions while blindfolded.. The subject must duplicate the position generated by the examiner. The next group of items (9-20) requires the subject to copy movements modeled by the examiner without verbal directives. Items 21 to 24 involve speeded, coordinated movements of both hands. Items 25 to 27 require the subject to pretend to carry out common, everyday activities, such as pouring and stirring a cup of tea. The next series of 8 items focuses on oral motor skills and included simple movements of the mouth and tongue, pretended movement, and coordination of oral movements, under speed conditions. Items 36 to 48 involve speed and accuracy in drawing common geometric figures (circle, square, triangle) from verbal and visual cues. The final 4 motor items require the subject to carry out various motor activities from spoken commands (e.g., "If I say red, squeeze my hand. If I say green, do nothing").

RHYTHM SCALE. Items on this scale address the ability to perceive and discriminate pitch, musical melodies, and reproduce tone, rhythm, and melody. All items except 2 require the subject to listen to recorded stimulus material from a cassette tape recorder. The first 3 items require the subject to discriminate between either two tones or two melodies, determining if they are the same or different. Items 55 to 57 require the subject to hum tones or sing lines from songs. The next set of items requires the subject to listen and count beeps played from the tape. The final 2 items require the subject to reproduce musical melodies by tapping rhythms with the hands.

TACTILE SCALE. This scale is administered while the subject is blindfolded. The subject is required to discriminate locus of touch on both hands, discriminate between sharp and dull touches and hard and soft touches, discriminate between one and two point stimulation at various widths, perceive designs, letters and numbers traced on the wrists, and reproduce standard arm positions placed by the examiner. The final items, number 32 to 85, involve stereognosis or the ability to tell by touch the name of four common objects placed in the hands. These final items are also timed.

VISUAL (SPATIAL) SCALE. This scale focuses upon visual perception, spatial orientation, and higher level spatially based problem solving. Items 86 to 91 require the subject to identify items in pictures which vary in complexity and clarity. Items 92 and 93 require analysis of complex visual patterns similar to the Raven's Progressive Matrices under time constraints. Items 94 to 96 involve the reading and drawing of clocks and the ability to detect direction using a compass. Items 97 to 99 involve higher level spatial reasoning and visualization skills. The subject is required to count the number of blocks in various three dimensional block sketches, and mentally rotate geometric figures in order to match them with similar figures, both under speeded conditions.

RECEPTIVE SPEECH. This scale addresses the subject's ability to understand the speech of others. Items 100 to 107 involve the ability to hear and reproduce speech sounds spoken by the examiner, either by speaking or writing the sound, and the ability to discriminate between similar speech sounds. Items 108 to 116 require comprehension of words and commands which vary in complexity (e.g., one-step commands, five-step commands) and in response modality (e.g., pointing to body parts, orally defining words). Items 117 to 132 focus on more complex aspects of language comprehension, including understanding conflicting instructions ("If it is day now, point to the black card, and if it is night now, point to the gray card"), and understanding logical grammatical structures ("Will you tell me whether the 'father's brother' and the 'brother's father' are two persons or the sam person?"). These items are administered under speeded conditions.

EXPRESSIVE SPEECH. The Expressive Speech scale examines the subject's ability to use language to effectively express thoughts and ideas. The first 21 items (numbers 133 to 153) require the subject to articulate speech sounds and words from a spoken model or from a written stimulus. Items 154 to 156 require repetition of sentences. Naming and word finding abilities are tapped in Items 157 to 159. Fluency and automization of speech are assessed in Items 160 to 163 (e.g., counting to 20, saying the days of the week backward). The ability to generate speech about various topics is addressed in Items 164 to 169. The ability to use complex rules of grammar in verbal expression is evaluated in Items 170 to 174.

WRITING. The Writing scale evaluates both motor writing and spelling tasks. Items 177-185 assess motor writing ability, copying, and spelling skills. Items 175 and 176 address phonetic skills and simple spelling skills, from a simple to moderately complex level (e.g., spelling "physiology"). Items 186 - 187 evaluate the subject's ability to write their ideas in a fashion that is grammatically accurate, with proper spelling and logical content.

READING. The Reading scale also assesses phonetic skills (Items 188-189), requiring the subject to describe sounds and words spelled out by the examiner (e.g., "What word is made by the letters 'k-n-i-g-h-t'"). Items 190 to 198 tap reading skills from the identification of letters to the oral reading of unfamiliar words (e.g., "astrocytoma"). Items 199-200 require the subject to read a brief paragraph orally, which is scored for both accuracy and speed.

ARITHMETIC. This scale assesses the fundamental aspects of mathematics, including basic number concept, number reading, and number writing (Items 201 to 211) and the ability to solve simple arithmetic problems mentally and on paper (Items 212 to 217). Items 218 to 220 tap understanding of arithmetic operations and signs, and simple algebraic operations. The final 2 items assess the ability to perform serial subtractions under time constraints (Items 221, 222).

MEMORY. The Memory scale assesses different aspects of immediate recall and learning ability. Items 223 to 225 require the subject to learn and repeat a series of seven words spoken at a one-per-second pace by the examiner. The task allows up to five presentations of the word list and requires two consecutive correct trials to reach criterion. Item 226 involves the ability to recognize a complex visual stimulus presented on a card for 5 seconds after a 30 second delay. Item 227 requires the subject to draw five geometric designs presented visually for 7 seconds after the visual stimulus is withdrawn. Items 228 to 230 require the recall of rhythmic patterns tapped on the tabletop, hand positions modeled by the examiner, and the repetition of five words presented on a card after a five-second exposure. Items 231 to 233 require word and sentence learning under conditions of interference, and Item 234 taps the ability to recall pertinent facts from an orally presented story. The final Memory scale, item (#236) assesses the ability to form and recall associations between words spoken by the examiner and pictures presented simultaneously to the subject.

INTELLECTUAL PROCESSES SCALE. This scale provides a brief assessment of intellectual and conceptual functions with items similar to those found in more extensive intelligence tests. Items 236 and 237 require the subject to verbally explain the activities presented in pictures. Items 238 to 240 are picture arrangement tasks similar to those found on the WAIS, requiring the sequential logical ordering of picture series under time constraints Items 242 and 243 assess the subject's ability to interpret abstract humor from cartoon drawings. Item 244 to 248 parallel the first 8 items, but are presented aurally rather than pictorially (e.g., "What is meant by the saying 'Don't count your chickens before they have hatched'?"). Items 249 and 250 assess similarities and differences between objects, and Items 251 and 254 assess the ability to comprehend logical relationships (e.g., "If we start with the part 'wall' then the whole will be 'house'. What will the whole be if the parts are 'pages?'"). Items 255 to 257 assess concepts including opposites and analogies. The final 12 items (258 to 269) assess the ability of the subject to perform mental arithmetic word problems under speeded conditions.

In addition to the 11 clinical scales, a pathognomonic scale, and right and left hemisphere sensorimotor scales, made up of items contained in other scales, are included. Scores on 8 empirically derived localization scales (left and right frontal, sensorimotor, parietal-occipital, and temporal lobe scales), and 30 factor scales which allow for more detailed analysis of functions within broad neuropsychological categories are also obtained. Following is a list of the LNNB factor scales.

M1	Kinesthetic-based Movements
M2	Drawing Speed
M3	Fine Motor Speed
M4	Spatial-based Movement
M5	Oral Motor Skills
Rh1	Rhythm and Pitch Perception
T1	Simple Tactile Sensation
T2	Stereognosis
V1	Visual Acuity and Naming
V2	Visual-Spatial Organization
Rc1	Phonemic Discrimination
Rc2	Using Relational Concepts
Rc3	Concept Recognition
Rc4	Verbal-Spatial Relationships
Rc5	Word Comprehension
Rc6	Logical Grammatical Relations
E1	Simple Phonetic Reading
E2	Word Repetition
E3	Reading Polysyllabic Words
Rg1	Reading Complex Material
Rg2	Reading Simple Material
W1	Spelling
W2	Motor Writing Skills
A1	Arithmetic Calculations
A2	Number Reading
Me1	Verbal Memory
Me2	Visual And Complex Memory
I1	General Verbal Intelligence
I2	Complex Verbal Arithmetic
I3	Simple Verbal Arithmetic

INTERPRETATION

Responses to the LNNB items are converted to a three-point scoring system from "0" reflecting no impairment to "2" reflecting performance which is within a brain-damaged range. Raw scores are converted to T scores with a mean of 50 and a standard deviation of 10. An age and education corrected "critical level" is computed to account for the effects of these factors on test performance. Brain-damaged performance is inferred if scores exceed the subject's critical level. Figure 1 displays a profile of LNNB clinical scores with the "critical level" adjusted for age and education.

The LNNB takes roughly two and one-half hours to administer. The test is amenable to rest breaks, which is particularly important because of potential difficulties in testing psychiatrically disabled subjects.

The test construction and procedures of the LNNB are particularly relevant to assessment of the psychiatrically disabled. Unlike other battery approaches such as the Halstead-Reitan, the LNNB was designed to eliminate as much as possible the effects of psychiatric symptoms, such as anxiety and depression by adopting items that combine demands on motor speed with scoring for accuracy of performance. The use of short, independent items (no task takes longer than two minutes to complete) rather than longer subtests, serves to minimize the negative effects of attention and concentration deficits, common in patients with psychiatric disorders, upon overall performance. Administration was designed to allow patients to perform at their maximum level by providing frequent breaks when necessary and by allowing the examiner to inform the patient when their test approach is counterproductive to their best score.

Excerpted from M. McCue, Assessment service in psychiatric rehabilitation. In L. Katz & M. McCue (Eds.), Psychiatric rehabilitation: A handbook for practitioners. St. Louis: Warren Green (in press).

Attention Tests

PERCEPTUAL SPEED. This cancellation task differs from others in that the target shifts with each line. The test consists of two pages of 25 rows of 30 randomized digits. The first digit in a line is the target digit. The PS measures both speed of visual tracking and ability to shift attention.
L.J. Moran & R.B. Mefferd, Jr.

PACED AUDITORY SERIAL ADDITION TEST (PASAT). This test simply requires that the subject add 60 pairs of randomized digits so that each is added to the digit immediately preceding it. The digits are presented at four rates of speed (ranging from 1.2 seconds to 2.4 seconds).
D.M.A. Gronwall

THE STROOP COLOR-WORD TEST. This is a measure of concentration and mental control which requires the subject to label colors of print which spell out conflicting names of colors. Raw scores are obtained for 45-second preliminary reading and naming trials, and for 45-second interference trial. An interference score is also calculated.
Charles Golden

MATCHING FAMILIAR FIGURES TEST (MFFT). The test is essentially a measure of impulsivity. Subjects are required to select the two matching figures from a series of six figures. Quick response times suggest impulsivity and inattention to detail.
J. Kagan, B. Rosman, et al.

DIVIDED ATTENTION. This task requires a subject to attend to two different response sets simultaneously (for example remembering a numerical series while identifying each digit as even or odd). Mental flexibility and auditory attention are assessed.
D. Wechsler

CONTINUOUS PERFORMANCE TEST (CPT). This task measures the capacity to sustain attention or concentration. Letters are randomly presented on a micro-computer monitor at the rate of one every two seconds. Whenever a target stimulus appears after a designated stimulus (e.g., "X" following a "T"), the subject must depress the computer keyboard space bar as quickly as possible. The task is given under two different conditions: a) nondistracting, and b) distracting. In the nondistracting condition, the subject responds only to the stimuli ("X" following a "T"). In the

distractor condition the subject must ignore randomly interspersed auditory tones of varying duration and frequency generated from the computer. This latter task is particularly useful for clarifying if there is a susceptibility to distraction in individuals as is suggested from the available evidence. Each part takes 15 minutes.
Adapted by R. Tarter, et. al. from the work of J. Rosvold, A. Mirsky, et. al.

Memory Tests

RIVERMEAD BEHAVIOURAL MEMORY TEST. This test was developed to detect impairment in everyday memory functioning and has been used to monitor change following treatment for memory difficulties. The items involve either remembering to carry out some everyday task or retaining the type of information needed for adequate everyday functioning (e.g., remembering a name, appointment, face). These items are combined with conventional memory measures such as digit span, logical memory and paired associate learning. Four versions of the RBMT are available to reduce the practice effects of repeated testing.
Barbara Wilson, Janet Cockburn, Alan Baddeley

THE WECHSLER MEMORY SCALE. Is used to assess immediate and delayed (intermediate) recall of verbal material presented aurally in story form (Logical Memory), related and unrelated word pairs presented aurally (Paired Associational Learning), and recall and reproduction (drawing) of geometric figures presented visually. Delayed recall (30 minutes) may also be administered consistent with procedures developed by Russell (1975).
David Wechsler & C.P. Stone

CALIFORNIA VERBAL LEARNING TEST (CVLT). This memory test assesses recall of word lists under a variety of conditions including free recall, interference, categorical cues and delayed recall
D. Delis, J. Kramer, et al.

Language Tests

BOSTON DIAGNOSTIC APHASIA TEST (BDAE): NAMING AND FLUENCY TASKS. These tasks require the subject to name various items from visual and verbal cues, repeat phrases, and generate words from specified categorical areas such as words beginning with a designated letter or kinds of animals. The tests are taken from the Boston Diagnostic Aphasia Examination (Goodglass & Kaplan, 1983).
Harold Goodglass

TOKEN TEST. The Token Test involves presenting a display of colored tokens of various colors and shapes and asking the subject to follow instructions for manipulating the tokens (e.g., "Put the red circle on the green square"). The test is a measure of attention and comprehension of spoken language.
F. Boller & L.A. Vignolo

Visual Perceptual Tests

COMPLEX FIGURE TEST (CFT). The CFT (Osterrieth, 1944) is a complex drawing task in which the subject is required to copy a figure consisting of 18 scoreable components. The test is untimed but time to complete is recorded. Data are available on normal adult performance. Each of 18 components are scored from 2 (correct and properly placed) to 0 (absent or not recognizable). A maximum of 36 points is attainable. The procedure usually takes less than 10 minutes to administer.
A. Rey & P.A. Osterrieth

JUDGMENT OF LINE ORIENTATION. This test examines the ability to estimate angular relationships between line segments by visually matching angled line pairs in 11 numbered radii forming a semi-circle. Two forms of the test are available.
Arthur Benton & Colleagues

TEST OF FACIAL RECOGNITION. This test was developed to examine the ability to recognize faces without involving a memory component. The subject matches identical front views, front with side views and front views taken under different lighting conditions. Administration time ranges from 10-20 minutes depending on subject's response rate and cautiousness in making choices.
Arthur Benton & Colleagues

VISUAL FORM DISCRIMINATION. This test examines the ability to match complex geometric patterns. Subject responses are scored as correct, peripheral error, major rotation or a major distortion.
Arthur Benton & Colleagues

HOOPER VISUAL ORGANIZATION TEST. This is a test requiring conceptual reorganization of disarranged pieces. This test is comprised of thirty pictures of more or less readily recognizable cut-up objects. The subject is asked to name each object verbally or by writing the name of the object on the test booklet.
H. Elston Hooper

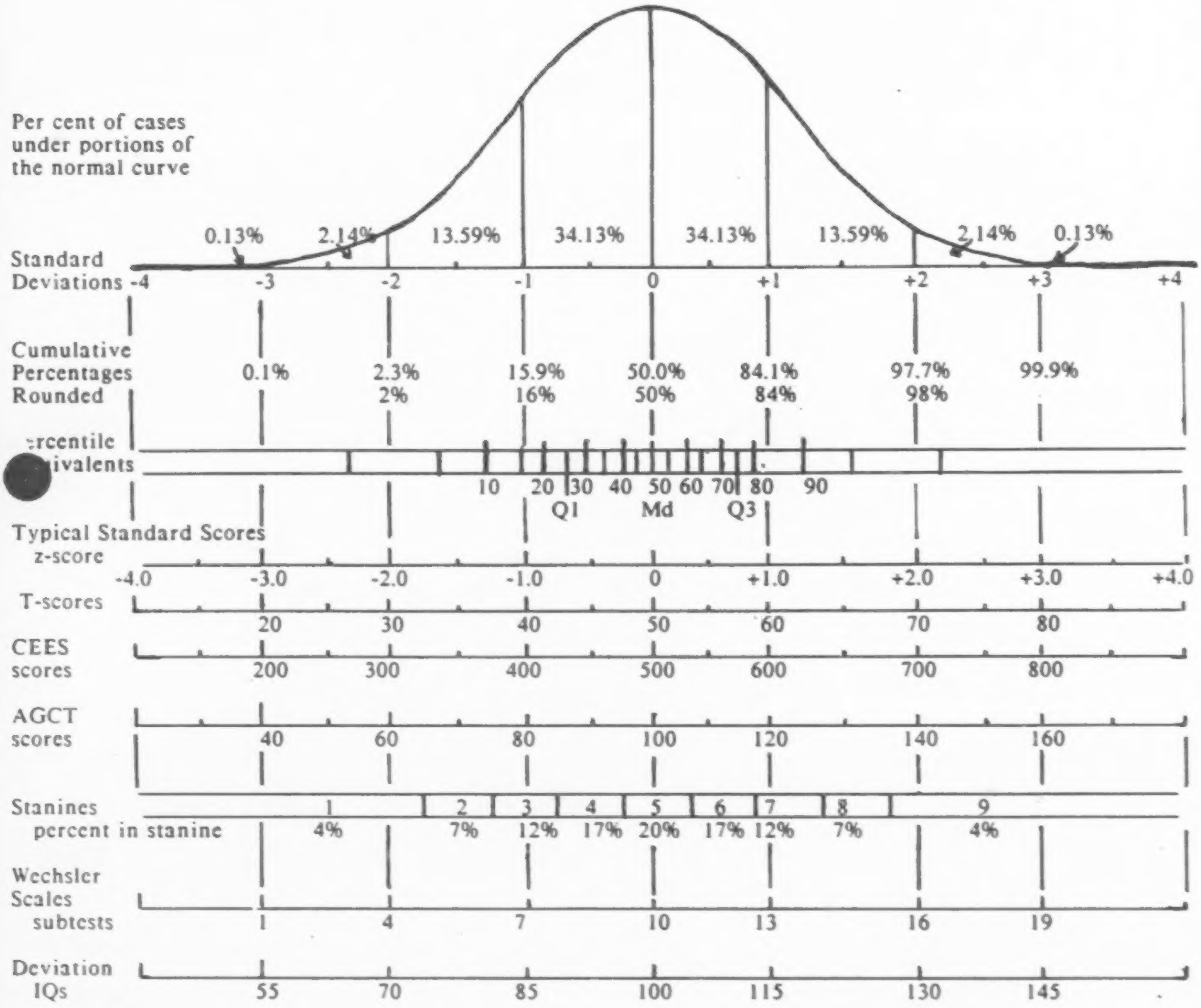
Problem Solving Tests

SYMBOL DIGIT MODALITIES TEST. A substitution task in which the subject must fill in as rapidly as possible numbers for geometric symbols in conformity with a code provided. Although similar to the WAIS Digit Symbol subtest, it is normed for brain damaged and non-brain damaged patients and involves substitution of numbers for symbols rather than the reverse. This test may also be given orally by having a subject call out the numbers.
Aaron Smith

PORTEUS MAZES. The maze tracing task was designed to yield data about the highest levels of mental functioning involving planning and foresight. There are three sets of the Porteus Maze Test to compensate for practice effects in retesting. To achieve a successful trial, the subject must trace the maze without entering any blind alleys.
S.D. Porteus

WISCONSIN CARD SORTING TEST (WCST). The WCST is a test devised to study abstract thinking and the ability to shift mental sets. The subject is given a pack of 64 cards on which are printed one of four symbols, triangle, star, cross, or circle, in red, green, yellow, or blue. No two cards are identical. The subject's task is to place them one by one under four stimulus cards - one red triangle, two green stars, three yellow crosses, and four blue circles - according to a principle that the subject must determine from the pattern of the examiner's response to the placement of the cards. The examiner shifts between principles based upon concepts of form, color, and number. Scoring is the number of correct categories achieved by using a pack of 128 cards. The number of perseverative responses may also be scored. This score is useful in documenting problems in forming concepts, profiting from correction, and conceptual flexibility.
David A. Grant & Esta A. Berg

CHART COMPARING VARIOUS TEST SCORES AND THEIR CORRESPONDENCE TO EACH OTHER



igure 1. Relationships among the normal curve, relative standing expressed in percentiles, and various derived scores. (Reprinted from Test Service Bulletin No. 50, Courtesy of the Psychological Corporation.)

NORM

TABLE E.

Relationships Among Several Standard Score Scales and the Extended Percentile Rank Scale.

Standard Score ($M = 100$, $SD = 15$)	T-Score ($M = 50$, $SD = 10$)	Stanine ($M = 5$, $SD = 2$)	Normal Curve Equivalent (NCE) ($M = 50$, $SD = 21.06$)	Extended Percentile Rank
>160	>90	9	99	99.9
160	90	9	99	99.9
159	89	9	99	99.9
158	89	9	99	99.9
157	88	9	99	99.9
156	87	9	99	99.9
155	87	9	99	99.9
154	86	9	99	99.9
153	85	9	99	99.9
152	85	9	99	99.9
151	84	9	99	99.9
150	83	9	99	99.9
149	83	9	99	99.9
148	82	9	99	99.9
147	81	9	99	99.9
146	81	9	99	99.9
145	80	9	99	99.9
144	79	9	99	99.8
143	79	9	99	99.8
142	78	9	99	99.7
141	77	9	99	99.7
140	77	9	99	99.6
139	76	9	99	99.5
138	75	9	99	99.5
137	75	9	99	99
136	74	9	99	99
135	73	9	99	99
134	73	9	98	99
133	72	9	96	99
132	71	9	95	98
131	71	9	94	98
130	70	9	92	98
129	69	9	91	97
128	69	9	89	97
127	68	9	88	96
126	67	9	87	96
125	67	8	85	95
124	66	8	84	95
123	65	8	82	94
122	65	8	81	93
121	64	8	79	92
120	63	8	78	91
119	63	8	77	90
118	62	8	75	88
117	61	7	74	87
116	61	7	72	86
115	60	7	71	84
114	59	7	70	82
113	59	7	68	81
112	58	7	67	79
111	57	7	65	77
110	57	6	64	75
109	56	6	63	73
108	55	6	61	70
107	55	6	60	68
106	54	6	58	66
105	53	6	57	63
104	53	6	56	61
103	52	5	54	58
102	51	5	53	55
101	51	5	51	53
100	50	5	50	50

NORM
TABLE E.
Relationships Among Several Standard Score Scales and the Extended Percentile Rank Scale.

Standard Score (*M* = 100, *SD* = 15)	**T-Score** (*M* = 50, *SD* = 10)	**Stanine** (*M* = 5, *SD* = 2)	**Normal Curve Equivalent (NCE)** (*M* = 50, *SD* = 21.06)	**Extended Percentile Rank**
99	49	5	49	47
98	49	5	47	45
97	48	5	46	42
96	47	5	44	39
95	47	4	43	37
94	46	4	42	34
93	45	4	40	32
92	45	4	39	30
91	44	4	37	27
90	43	4	36	25
89	43	4	35	23
88	42	3	33	21
87	41	3	32	19
86	41	3	30	18
85	40	3	29	16
84	39	3	28	14
83	39	3	26	13
82	38	3	25	12
81	37	3	23	10
80	37	2	22	9
79	36	2	21	8
78	35	2	19	7
77	35	2	18	6
76	34	2	16	5
75	33	2	15	5
74	33	2	13	4
73	32	2	12	4
72	31	1	11	3
71	31	1	9	3
70	30	1	8	2
69	29	1	6	2
68	29	1	5	2
67	28	1	4	1
66	27	1	2	1
65	27	1	1	1
64	26	1	1	1
63	25	1	1	1
62	25	1	1	0.5
61	24	1	1	0.5
60	23	1	1	0.4
59	23	1	1	0.3
58	22	1	1	0.3
57	21	1	1	0.2
56	21	1	1	0.2
55	20	1	1	0.1
54	19	1	1	0.1
53	19	1	1	0.1
52	18	1	1	0.1
51	17	1	1	0.1
50	17	1	1	0.1
49	16	1	1	0.1
48	15	1	1	0.1
47	15	1	1	0.1
46	14	1	1	0.1
45	13	1	1	0.1
44	13	1	1	0.1
43	12	1	1	0.1
42	11	1	1	0.1
41	11	1	1	0.1
40	10	1	1	0.1
<40	<10	1	1	0.1

Summary of Test Score Characteristics

Score	Description	Example	Limitations
Raw Score	The number of questions answered correctly.	A raw score of 40 means that the student answered 40 of the test questions correctly.	Raw scores are meaningful only within the context of a test's length and difficulty. Raw scores for one test or subtest should not be compared with those for another test or subtest.
PR (Percentile Rank)	Indicates where a raw score fits within the range of scores obtained by the national norming group. Tells the percentage of students in the same grade in the norming group whose raw scores were lower.	A PR of 60 means that the student's raw score was higher than that of 60% of the students in the same grade in the norming group.	PRs should not be averaged directly; a group PR can be obtained by averaging ESSs and finding the PR that corresponds to the average ESS. Should not be used to compare scores.
NCE (Normal Curve Equivalent)	A statistical (normalized) transformation of PRs in which the range of reading achievement is divided into 99 equal units with a mean of 50 and a standard deviation of 21.06.*	An NCE of 60 means the raw score is about one-half standard deviation above average. (It corresponds to a PR of 68.)	
Stanine	A statistical (normalized) transformation of PRs in which the range of reading achievement is divided into 9 equal units with a mean of 5 and a standard deviation of 2.*	A stanine of 6 means that the raw score is above average. (It corresponds to the group of PRs that range from 61–76.)	Each stanine provides only a broad measure of achievement. Stanines are more useful for individual than for group scores.
ESS (Extended Scale Score)	An equal-unit scale extending from the lowest achievement in Grade 1 to the highest achievement in Grade 12. Developed so that progress in reading can be followed over a period of years.	ESSs have no direct normative meaning. One can learn, from the norms tables, the ESSs that are characteristic of the grade level of the students being tested.	An unfamiliar scale. Vocabulary, Comprehension, and Total ESSs are not comparable.
GE (Grade Equivalent)	Tells the grade level for which the score would have been the median score, if the test had been given at that grade level. Scores range from 1.0 to 12.9. Scores below Grade 1 are labeled K (Kindergarten); scores above Grade 12 are labeled PHS (Post High School).	A GE of 6.0 means that the student's score is about the same as would be expected of an average student in September of Grade 6, if that student had taken the same test.	Less meaningful when GEs are not within the intended grade ranges of the test level taken, the next lower level, and the next higher level. GEs should not be averaged directly; a group GE can be obtained by averaging ESSs and finding the GE that corresponds to the average ESS. Should not be used to compare scores.

*The lowest and highest NCE and stanine units are larger than the others, since they include all extreme scores at the ends of the scales.

from Gates-MacGinitie manual

Types of Test Scores

Raw Scores

The raw score is the number of questions answered correctly. In itself, a raw score for a test does not tell much about a student's reading achievement; its meaning lies in the other scores that can be derived from it by using the tables of norms. To say that June got a raw score of 37 is to say very little about how well June did. This is because the meaning of the raw score, the level of achievement that it represents, depends on how long, and how hard, the test is.

Because tests differ in length and difficulty, a raw score of 37 on one test is not likely to be equivalent to a raw score of 37 on another. So comparing raw scores on different tests is likely to result in misunderstanding the relationship between the scores.

The derived scores were developed from raw scores that were obtained during the standardization testing by a nationwide, representative group of students—the students in the norming group. Since the derived scores are based on the percentages of the students who obtained each possible raw score, they measure how well a student has done *in comparison with the students in the norming group.* Thus, they provide a statement of the comparative level of achievement that each raw score represents.

> For example, in October, 84% of the Grade 11 norming group students got raw scores below 37 on the Level 10/12, Form K Vocabulary Test. The derived scores for 37 (stanine of 7, NCE of 71, PR of 84, Post High School GE, and ESS of 680) all indicate that a Grade 11 student with a raw score of 37 on that test in October reads quite well, in comparison to the students in the norming group. The student's level of achievement is quite high for his or her grade.

Of course, in using any test scores, it is important for teachers and others in the schools to take into account whatever else is known about the students who took the test.

Derived Scores

Percentile Ranks (PRs)

A percentile rank (PR) indicates where a raw score fits within a range of scores; it describes the position of a raw score obtained by a particular student in a particular grade within the set of scores obtained during the standardization testing by students in the same grade. The PR for a particular raw score tells the percentage of students in that same grade whose raw scores were lower.[1]

> Earl's raw score corresponds to a PR of 40; 40% of the students in Earl's grade who took the test during the standardization had a raw score lower than Earl's. Put another way, Earl's raw score was higher than the scores of 40% of these students.

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[1] Any one raw score was, in fact, obtained by many students in the norming group. So, in computing a PR for a particular raw score, the group of students who got that particular raw score was divided in half; half was included with students who got lower raw scores, and half with students who got higher raw scores.

The PR that corresponds to any one raw score on a particular test decreases from fall to spring, and from grade to grade. This is because students learn more about reading as they progress through school. Students who take the same test at the beginning and at the end of the year usually get higher raw scores at the end of the year. As a result, at the end of the year, fewer students have raw scores lower than any given raw score. So the PR that corresponds to any one raw score is lower at the end of the year than it is at the beginning.

> For example, a Vocabulary Raw Score of 28 on Level 7/9, Form K corresponds to a PR of 68 for a Grade 7 student in the fall; at that time, 68% of the students in the norming group got raw scores below 28. By the spring, fewer Grade 7 students get raw scores below 28. So, in the spring of Grade 7, the same raw score of 28 corresponds to a PR of only 58. To have a PR of 68 in the spring of Grade 7—to do better than 68% of seventh graders in the spring—a student would have to get a raw score of 31.

Percentile ranks do not represent equal units of reading achievement the way that meters represent equal units of distance. A PR unit (the difference between one PR and the next) that is near 50 (near the average) is smaller than one that is near 10 or 90.[2] So, for example, the difference in reading achievement between PRs of 50 and 60 is small; if the PRs were 80 and 90, the difference would be much larger. It follows that using PRs to make comparisons is likely to be misleading.

> Susan has a PR of 35; Jason, a PR of 50; and Michael, a PR of 20. Susan's PR is numerically halfway between Jason's and Michael's. Susan's level of reading achievement, however, is closer to Jason's than to Michael's.

Because PR units are not equal, PRs should not be averaged.

NCEs (Normal Curve Equivalents)

Like PRs, NCEs describe a student's level of reading achievement in terms of relative standing within a group of students at the same grade level. NCEs, in fact, are based on PRs. They are PRs that have been transformed statistically into a scale of *equal* units of reading achievement.[3] The NCE scale is designed so that NCEs of 1, 50, and 99 coincide with PRs of 1, 50, and 99. Although NCEs can actually be lower than 1 and higher than 99, they are limited to a range of 1 through 99 in the tables of norms to conform to typical guidelines for program evaluation.

Except for NCEs of 1 and 99, each NCE unit is the same throughout the scale. So NCEs are suitable for computing averages; they are also suitable for making comparisons between scores.

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[2] The reason that PRs near the average represent smaller differences in achievement is that most students are about average in reading; relatively few have a high or low level of reading achievement. A student who has made a modest increase in reading achievement (relative to the norming group) will have made a considerable gain in PR if the student was about average to begin with; that is because he or she will have surpassed the achievement of many others whose achievement was also about average. A student who is well above average to begin with, and who makes the same modest increase in reading achievement, will gain only slightly in PR; he or she will have surpassed the achievement of relatively few others whose achievement was also well above average.

[3] NCEs are normalized standard scores with a mean of 50 and a standard deviation of 21.06.

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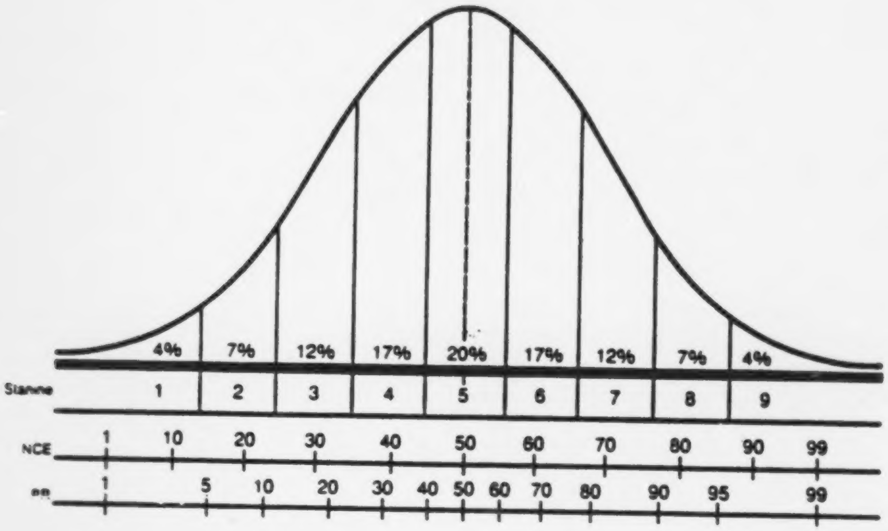
Stanines

Stanines, like PRs and NCEs, describe a student's level of achievement in relation to the achievement of other students in the same grade. Like NCE units, each unit in the stanine scale is equal, except for the lowest and highest units.[4] But *stanines* divide the continuum of reading achievement into only *nine* score segments. Since stanines measure reading achievement in relatively broad bands, they tend to discourage focusing on score differences that may be not meaningful. And because stanines are broad bands, they are more useful for individual than for group scores.

The figure below shows the difference between PRs on the one hand, and standard scores, such as NCEs and stanines, on the other. In a normal distribution of reading achievement, PRs are close to each other near the middle, and more distant at the extremes; most students are about average, and few are exceptional. The NCEs and stanines are equally spaced; they measure achievement in equal units.

Relation between Stanines, NCEs, and PRs



Extended Scale Scores (ESSs)

The extended scale scores (ESSs) were developed so that progress in reading can be followed over a period of years on a single, continuous scale. Percentile ranks, NCEs, and stanines rank a student's achievement within his or her own grade group. ESSs, in effect, rank a student's achievement within a group that includes all the students in all the grades; they relate a student's achievement to the entire range of achievement during the school years. The ESS scale, like the NCE scale, measures reading achievement in equal units, so that a difference of, say, 50 ESS units represents the same difference all along the scale.

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[4] Stanines are normalized standard scores with a mean of 5 and a standard deviation of 2. Each stanine (except 1 and 9) is one-half standard deviation wide. A stanine of 5 includes a quarter of a standard deviation both above and below the mean.

Scales of the ESS type are usually developed by choosing a group of students near the middle of the achievement continuum, say, Grade 5 or Grade 6 students, and using the norms for that group as a basis for the entire scale. Several names, such as "expanded standard scores," "growth scale," "universal scale scores," and "developmental scale scores" are used for scores of this type.

For the *Gates-MacGinitie Reading Tests*, there are three ESS scales—one for Vocabulary, one for Comprehension, and one for Total Score. The scales are based on the raw score distributions of the Grade 5 norming group for the Second Edition. Average achievement (NCE of 50) at the beginning of Grade 5 (5.1) was represented by an ESS of 500; average achievement at the beginning of Grade 6 (6.1), by 525. Thus, a difference of 25 ESS units anywhere on the scales represents the difference between the achievement of beginning Grade 5 and beginning Grade 6 students at the time the Second Edition was standardized.[5] To provide for continuity from one edition of the test to the next, the same scales have been used for the Third Edition.

Since the rate of reading achievement growth tapers off during the school years, one would not expect the gain in ESSs to be the same from year to year; since the course of achievement growth is different for vocabulary and comprehension, one would not expect the gains in ESSs for Vocabulary and Comprehension to be the same; and, since the rate of growth is different for students who do not read well than it is for students who do, the gains in ESSs will not be the same from student to student. In order to interpret ESSs, you must know the Vocabulary and Comprehension ESSs that are characteristic of students at the grade level you are teaching.

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[5] To understand ESSs, it is useful to know how they were developed for the Second Edition. As an example, take the Total Score ESSs: An ESS of 500 was assigned to a Total NCE of 50 at Grade 5.1; an ESS of 525 was assigned to a Total NCE of 60 (the Grade 5.1 equivalent of a Grade 6.1 NCE of 50). Other ESSs were assigned proportionately to other Grade 5.1 NCEs (and their corresponding raw scores).

The scale was then extended to other test levels on the basis of special equating testing. In this testing, groups of students took two adjacent levels of the tests, so that equivalent raw scores and NCEs for adjacent level tests could be determined.

> For example, one large group of students took both the fourth through sixth grade test (Level D) and the seventh through ninth grade test (Level E). Since 70% of these students got a total raw score below 73 on the Level D test, and 70% of the same students got a total raw score below 58 on the Level E test, the two raw scores, and the NCEs that corresponded to those raw scores, were considered equivalent. Thus, since Level D and Level E total raw scores of 73 and 58 were considered equivalent, their corresponding NCEs—a Grade 5.1 NCE of 80 and a Grade 7.1 NCE of 61—were also considered equivalent.

The ESS already assigned to a Grade 5.1 NCE was the basis for the ESS assigned to the equivalent Grade 7.1 NCE. However, though ESSs for the two equivalent NCEs are similar, they are not identical, because the linear relationship between *all* the Grade 5.1 NCEs and their Grade 7.1 equivalents was applied in computing the Grade 7.1 ESSs.

> In the example, an ESS of 578 had been assigned to the Grade 5.1 NCE of 80; the ESS of 577 that was computed for the equivalent Grade 7.1 NCE is similar.

The equating of scores and assigning of ESSs to equivalent NCEs for different test levels was then carried out repeatedly, until ESSs were assigned to appropriate NCEs, and to corresponding raw scores, for each test level.

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You can find this kind of information for Levels 7/9 and 10/12 in the norms tables. For example, the ESS (576) that corresponds to an average Total score (PR of 50) at the beginning of Grade 8 can be found by reading across the row that contains 50 in the Fall PR column in the Grade 8 norms for Level 7/9. The ESS (588) that corresponds to an average Total score near the end of the year can be found by reading across the row that contains 50 in the Spring PR column.[6] Similarly, you can find ESSs that correspond to any other PR at the beginning and end of any grade for which norms are given. Simply read across the rows that contain that particular PR.

Neither the month nor the grade in which a student takes the test changes the ESS; a particular raw score on a particular level and form of a test will always correspond to the same ESS.

Grade Equivalents (GEs)

Grade equivalents (GEs), like ESSs, rank a student's achievement within a group that includes the students in all the grades. They do this by estimating the grade level of the group whose median ESS would be the same as the student's ESS.

> Lisa, whose Comprehension GE is 8.6, has an achievement level estimated to be equivalent to the achievement level of an average student who has been in Grade 8 for 6 months.

The whole number in a GE represents the grade; the decimal fraction represents a month in the school year (or roughly a tenth of the school year). For a school year beginning in September, the decimal values corresponding to the different months are

Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
.0	.1	.2	.3	.4	.5	.6	.7	.8	.9

GEs for October and April, the months of the standardization testing, represent the median scores achieved in those months by the norming group. Thus, a GE of 9.1 corresponds to the median ESS of the Grade 9 norming group in October; a GE of 9.7 corresponds to the group's median ESS in April. GEs for other months are estimates; they correspond to ESSs that would be the median scores if increases in scores were the same from month to month. Of course, actual growth in reading achievement is not necessarily constant throughout the school year.

As with ESSs, neither the month nor the grade in which a student takes the test changes the GE; a particular raw score on a particular level and form of a test will always correspond to the same GE. Of course, a Grade 6 student whose score on a Level 7/9 test corresponds to a GE of 9.6 is reading well above average, while a Grade 11 student who got the same score on the test is reading slightly below average.

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[6] In the Level 7/9, Form K Total Score norms for Grade 8, a PR of 50 is not actually listed for spring. A PR of 50 would be about two-thirds of the way between 48 and 51, which *are* listed. So the ESS that corresponds to a PR of 50 in the spring would be about two-thirds of the way between ESSs of 586 and 589, which correspond to spring PRs of 48 and 51.

GEs can be useful scores, but before you interpret them, you should understand the following characteristics and limitations:[7]

1. GEs within the intended grade range of a test level or of one level above or below it are relatively meaningful; they are based on the scores of students who took a test with similar content.

    If Kai-Sun gets a GE of 12.6 on the Level 7/9 Comprehension Test, he had a raw score like the score that a typical Grade 12 student would probably get on the same Level 7/9 test in the middle of the twelfth-grade year. He can probably read many high school materials successfully.[8]

    The table of "Norms Available for Each Level" on page 64 shows the intended grade range for each test level.

2. As GEs extend beyond the intended grade range of a test level and the levels immediately above and below it, their grade-level associations become increasingly less meaningful. A GE of, say, 10.1 for Level 4 is based on the scores of the Grade 10 norming group that took a Level 10/12 test—a test that is very different in content from the Level 4 test. GEs far from the intended grade level(s) of the test that was taken are based on scores on tests that may be much easier, or much more difficult, than the test that the student took.

    Thus, GEs far from the grade level(s) of the test that was taken should not be interpreted as indicating that a student can read, or can only read, like a student at a specified level far above or far below the grade level of the test.

    Wilma, who is in Grade 11, got a GE of 4.5 on a Level 10/12 Comprehension Test. This GE means that Wilma reads *very* poorly for an eleventh grader. It does *not* mean that she understands only those language structures that a typical student in the middle of Grade 4 understands; it does *not* mean that she has the interests of a fourth grader or that she should be given fourth-grade materials.

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[7] To avoid misinterpreting GEs, it is useful to know how they are computed. The method used to compute GEs for the *Gates-MacGinitie Reading Tests* consisted of the following steps:

1. GEs for each grade were determined from the ESSs of students in the same grade who took the test level designed for that grade during the standardization.

    For example, a GE of 9.1 was assigned to the median ESS of Grade 9 students who took a Level 7/9 test in October; a GE of 9.7 was assigned to the median ESS of Grade 9 students who took the same test in April. Similarly, GEs of 10.1 and 10.7 were assigned to median ESSs of Grade 10 students who took a Level 10/12 test in October and in April. GEs between 9.1 and 9.7, 9.7 and 10.1, and 10.1 and 10.7 were assigned to intermediate ESSs on the assumption that score increases are constant during each of those periods.

    Thus, GEs for each grade level were assigned to ESSs until the continuous ESS scale was accompanied by a parallel and corresponding GE scale that ranged from 1.0 to 12.9.

2. Once the GE scale was established, the GEs were applied, through their corresponding ESSs, to raw scores for other test levels. Of course, the lower test levels are not difficult enough to have GEs of 12.9 applied to any raw score; and, in the higher levels, some low GEs are applied to chance level raw scores that may not be good estimates of students' reading achievement.

[8] GEs are not estimates of instructional level. The grade level of appropriate instructional materials usually lies between a student's actual grade and his or her GE.

Martha, who is in Grade 6, took a Level 5/6 test and got a Comprehension GE of 12.1. She reads very well for a Grade 6 student; she has certainly learned more of what has been taught in Grades 1–6 than has the average sixth grader. The test she took, however, was one based on reading materials designed for the range of abilities and interests of most students in Grades 5 and 6. She is not necessarily reading in the same way, or capable of reading the same material, as the students who are actually in Grade 12. And, of course, her interests may not coincide with the interests that Grade 12 materials deal with.

3. GEs, like PRs, do not represent equal units of reading achievement. A gain of one grade level at the Grade 1 end of the GE scale represents a greater gain in achievement than a gain of one grade level at the Grade 12 end of the scale. This is because students typically learn most about reading in the primary grades, when they are first learning how to read and are applying to written language what they already know about spoken language. Then, as they move through the grades, the yearly change in what they know about reading usually becomes progressively smaller.

   Julio, in Grade 5, who is reading one year above grade level, is farther ahead of his grade group than is Lucy, in Grade 11, who is also reading one year above grade level.

   Because GEs do not represent equal units, they should not be used to compute averages.

4. The GE scale reflects the yearly growth of achievement of *average* students. Thus, the difference between 8.2 and 9.2 represents about a year's growth for an average student progressing through Grade 8 to Grade 9. Students who are considerably above average, however, typically grow in achievement at a faster rate; students who are considerably below average typically grow at a slower rate. The yearly growth of a student with a PR of 10 is likely to be less than one grade level, measured in GE units; similarly, the yearly growth of a student with a PR of 90 is likely to be more than one grade level, measured in GE units.

5. Like other derived scores, GEs are based on averages; they are not standards or criteria of performance. They do not tell how well a particular student *should* read; they tell how well the average student in a particular grade *does* read. The nature of averages dictates that about half the students in a typical class will have scores that are above the national average, and about half will have scores that are below average. So, in a typical Grade 9 class tested in April, many students will obtain GEs above 9.7 and many will obtain GEs below 9.7.

6. Comparing Vocabulary GEs with Comprehension GEs is likely to be misleading, because the relation between GEs on the one hand and PRs or NCEs on the other is different for Vocabulary and Comprehension. The table below gives an example of this difference. Vincent, Risa, and Masao took the Level 7/9, Form K Vocabulary and Comprehension Tests in the fall of Grade 7. Vincent's scores on both tests were close to the national average; for both tests, his PR was at, or close to, 50, and his GEs (7.0 and 7.1) were essentially at grade level. Risa's scores were both well above average, but she did better on Vocabulary (PR 91), in comparison with other students in her grade, than she did on Comprehension (PR 80). Yet, even though her Vocabulary PR was higher than her Comprehension PR, her GE (10.5) was the same for both tests. Masao's scores were also well above average; his PRs on the two tests were almost identical (91 and 90), but his Vocabulary GE (10.5) was lower than his Comprehension GE (12.6).

Relation between GEs and PRs for Vocabulary and Comprehension (Level 7/9, Form K, Fall of Grade 7)

	Vocabulary			Comprehension		
	Raw Score	PR	GE	Raw Score	PR	GE
Vincent	23	49	7.0	27	50	7.1
Risa	36	91	10.5	35	80	10.5
Masao	36	91	10.5	38	90	12.6

As the example shows, the same GE for Vocabulary and Comprehension does not necessarily indicate the same relative standing within a grade group; and the same relative standing is not necessarily reflected in the same GE. This is because the range of achievement relative to the rate of achievement growth is different for vocabulary and comprehension. The range of achievement in comprehension among students at any one grade level is broad, and the growth from grade to grade is relatively small compared to that range; the range of achievement in vocabulary is more narrow, and the growth from grade to grade is relatively large. It may be that vocabulary achievement depends more on what is specifically taught in school than comprehension achievement does.

10

WECHSLER ADULT INTELLIGENCE SCALE—REVISED (WAIS-R)

Co-authored by Joseph J. Ryan

> *When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was astonished at how much he had learned in seven years.*
>
> —Mark Twain

> *Youth thinks intelligence a good substitute for experience, and his elders think experience a substitute for intelligence.*
>
> —Lyman Bryson

Standardization
Deviation IQs and Scaled Scores
Reliability
Validity
Intercorrelations Between Subtests and Scales
WAIS-R IQs and Stratification Variables
Factor Analysis
Administering the WAIS-R
WAIS-R Short Forms
WAIS-R Subtests
Interpreting the WAIS-R
Assets of the WAIS-R
Limitations of the WAIS-R
Test Your Skill
Summary

BEST COPY

The Wechsler Adult Intelligence Scale – Revised (WAIS-R; Wechsler, 1981) is the latest edition of an instrument introduced in 1939. In its original version, it was called the Wechsler-Bellevue Intelligence Scale – Form I (Wechsler, 1939), after David Wechsler and Bellevue Hospital in New York City, where Wechsler served as chief psychologist. A second form of the Wechsler-Bellevue, Form II, was published in 1946. Form I was revised in 1955 and again in 1981. The WISC-R and WPPSI are also derivatives of the 1939 adult scale. Because this textbook focuses on testing children, use of the WAIS-R with examinees 16 to 17 years old will be highlighted.

The WAIS-R contains 11 subtests grouped into Verbal and Performance sections. The six Verbal Scale subtests are Information, Digit Span, Vocabulary, Arithmetic, Comprehension, and Similarities; the five Performance Scale subtests are Picture Completion, Picture Arrangement, Block Design, Object Assembly, and Digit Symbol. (Digit Symbol is similar to Coding B on the WISC-R.) The WAIS-R covers an age range from 16 years, 0 months to 74 years, 11 months. It overlaps with the WISC-R from 16 years, 0 months to 16 years, 11 months.

The WAIS-R is similar to the 1955 Wechsler Adult Intelligence Scale (WAIS; Wechsler, 1955). About 80 percent of the items are the same or only slightly modified. Some of the new items and revised procedures were developed on the basis of cultural considerations. For example, two of the WAIS-R Information items make reference to famous black Americans (Louis Armstrong and Martin Luther King). WAIS items that had proved to be either too easy or too hard were eliminated from the WAIS-R. Also, scoring procedures on the WAIS-R Digit Span were altered to increase the variability of scores.

STANDARDIZATION

The WAIS-R was standardized on 1,880 white and nonwhite Americans equally divided with respect to gender, selected to be representative of the U.S. late adolescent and adult population during the 1970s. The demographic characteristics used to obtain a stratified sample were age, sex, race (white = 1,664, black = 192, and Asians plus native Americans = 24), geographic region (Northeast, North Central, South, and West), education, and urban-rural residence. In the standardization sample, there were nine different age groups (16–17, 18–19, 20–24, 25–34, 35–44, 45–54, 55–64, 65–69, and 70–74), with 160 to 300 individuals in each group.

DEVIATION IQS AND SCALED SCORES

The WAIS-R, like the WISC-R and the WPPSI, employs the Deviation IQ ($M = 100$, $SD = 15$) for the Verbal, Performance, and Full Scales and standard scores for the subtests ($M = 10$, $SD = 3$). In order to obtain Deviation IQs, one first converts raw scores into scaled scores, using a table on the front of the WAIS-R record booklet or Table 19 in the WAIS-R manual. These scaled scores are based on a reference group of subjects in the standardization sample who were 20 to 34 years of age. The scaled scores are then summed, and the sum and the examinee's age are used to find Deviation IQs in Table 20 in the WAIS-R manual. Verbal Scale IQs are based on the sum of the six Verbal subtests, Performance Scale IQs on the sum of the five Performance subtests, and Full Scale IQs on all 11 subtests.

Prorating Procedure

The WAIS-R manual provides a table (Table 23) for prorating the scores when five of the Verbal Scale subtests are administered, or when four of the Performance subtests are administered. When even fewer subtests are administered, IQs should be computed by using the special short-form procedure described later in this chapter.

Scaled Score Equivalents for Age Groups

The WAIS-R manual (Table 21) also provides scaled score equivalents ($M = 10$, $SD = 3$) of raw scores for each of the nine age groups in the standardization sample. This table is useful in conducting profile analysis and in comparing an individual's performance *directly* with that of age peers; however, *the age-corrected scaled scores should not be used to calculate IQs. Age-corrected subtest scaled scores should be used only to make subtest interpretations and comparisons*. These age-corrected scores, in addition to the reference group scaled scores, should be recorded for every WAIS-R protocol to avoid interpretive errors.

RELIABILITY

The WAIS-R provides highly reliable IQs. Each of the three IQ scales has an internal consistency reliability coefficient of .88 or above in the standardization group over the entire age range covered by the scale. Reliability coefficients, based on a formula for computing the reliability of a composite group of tests, range from .95 to .97 (ave

r_{xx} = .97) for the Verbal IQ, from .88 to .94 (average r_{xx} = .93) for the Performance IQ, and from .96 to .98 (average r_{xx} = .97) for the Full Scale IQ. (Similar findings have been reported for a clinical sample by Ryan, Prifitera, and Larsen, 1982.)

The reliabilities for the individual subtests are less satisfactory than those for the IQs. They range from a low of .52 for Object Assembly at ages 16–17 to a high of .96 for Vocabulary at six of the nine age groups. The average reliability coefficients range from .68 for Object Assembly to .96 for Vocabulary (*Mdn* r_{xx} = .83). Similar findings have been reported for a clinical sample (Ryan et al., 1982). Table 10-1 presents the reliability coefficients for each subtest and scale for ages 16 to 17 and for the average of the standardization sample.

The highest reliabilities are found among the Verbal Scale subtests (average reliabilities range from .83 to .96). Block Design is the most reliable subtest (r_{xx} = .87) in the Performance Scale (average reliabilities in the Performance Scale range from .68 to .87). The reliability coefficients for 9 of the 11 subtests are split-half correlations corrected by the Spearman-Brown formula. For Digit Span and Digit Symbol, reliabilities are based on test-retest correlations because the items in these subtests do not lend themselves to the split-half calculation procedure.

Standard Errors of Measurement

The standard errors of measurement (SE_m) in IQ points, based on the average of the nine age groups, are 2.53 for the Full Scale IQ, 2.74 for the Verbal IQ, and 4.14 for the Performance IQ. Thus, more confidence can be placed in the Full Scale IQ than in either the Verbal or the Performance Scale IQ. The Verbal Scale subtests (average SE_m's

Table 10-1
Reliability Coefficients and Standard Errors of Measurement for WAIS-R Subtests and Scales for 16- to 17-Year-Olds and for the Average of the Nine Age Groups in the Standardization Sample

	Reliability coefficient		*Standard error of measurement*	
WAIS-R subtest or scale	*16- to 17-year-olds*	*Average of standardization group*	*16- to 17-year-olds*	*Average of standardization group*
Information	.90	.89	.84	.93
Digit Span	.70	.83	1.44	1.23
Vocabulary	.96	.96	.49	.61
Arithmetic	.73	.84	1.20	1.14
Comprehension	.78	.84	1.16	1.20
Similarities	.80	.84	1.29	1.24
Picture Completion	.71	.81	1.43	1.25
Picture Arrangement	.66	.74	1.47	1.41
Block Design	.87	.87	.97	.98
Object Assembly	.52	.68	1.91	1.54
Digit Symbol	.73	.82	1.53	1.27
Verbal IQ	.95	.97	3.30	2.74
Performance IQ	.88	.93	5.18	4.14
Full Scale IQ	.96	.97	2.96	2.53

Note. Reliability coefficients for 9 of the 11 subtests (all but Digit Span and Digit Symbol) are split-half correlations. For Digit Span and Digit Symbol, coefficients are based on test-retest data obtained on subsamples from the standardization group of 48 to 80 individuals in four age groups who were retested after a 1- to 7-week interval. Verbal, Performance, and Full Scale reliability coefficients are based on a formula for computing the reliability of a composite group of tests.
Source: Adapted from Wechsler (1981).

range from .61 to 1.24 scaled score points) usually have smaller standard errors of measurement than do the Performance Scale subtests (average SE_m's range from .98 to 1.54 scaled score points). Within the Verbal Scale, Vocabulary and Information have the smallest average SE_m's (.61 and .93 scaled score points, respectively); within the Performance Scale, Block Design and Picture Completion have the smallest average SE_m's (.98 and 1.25 scaled score points, respectively).

Stability

The stability of the WAIS-R was assessed by retesting two groups (71 individuals between the ages of 25 and 34 and 48 individuals between the ages of 45 and 54) in the standardization sample after an interval of two to seven weeks (Wechsler, 1981). The stability coefficients for ages 25 to 34 were .95 for the Full Scale IQ, .94 for the Verbal IQ, and .89 for the Performance IQ. For the 11 subtests, the stability coefficients ranged from .69 for Picture Arrangement to .93 for Vocabulary. The stability coefficients for ages 45 to 54 were generally similar to those for the younger group. For the three IQs, the stabilities again were high: .96 for the Full Scale IQ, .97 for the Verbal IQ, and .90 for the Performance IQ. Of the 11 subtests, Object Assembly had the lowest stability coefficient (r_{xx} = .67) and Information had the highest (r_{xx} = .94). The Verbal, Performance, and Full Scale test-retest IQs, standard deviations, and test-retest score changes for the two groups are shown in Table 10-2.

In the combined sample, the mean changes upon retest after two to seven weeks were 3.3 points on the Verbal IQ, 8.4 points on the Performance IQ, and 6.2 points on the Full Scale IQ (Matarazzo & Herman, 1984a). These differences likely reflect short-term practice effects. The practice effect was greater for the Performance Scale than for the Verbal Scale. The range of change was −12 to +15 for the Verbal Scale IQ, −12 to +28 for the Performance Scale IQ, and −12 to +20 for the Full Scale IQ. Thus, both gains and losses occurred on retest. Similar findings have been reported with adult clinical groups (Ryan, Georgemiller, Geisser, & Randall, 1985).

The test-retest stability coefficients for the three IQs were all highly significant, yet considerable within-subject variability was demonstrated. These findings underscore the distinction between psychometric and clinical retest stabilities (Matarazzo & Herman, 1984a). High psychometric stability is reflected by a sizable test-retest correlation, whereas high clinical stability is demonstrated by the absence of meaningful score change. For the standardization sample, psychometric stability was satisfactory, but clinical stability was unimpressive; over 80 percent of the subjects showed changes in Full Scale IQ that exceeded the average SE_m. The WAIS-R IQ appears to be less stable than one might infer from the test-retest coefficients alone, and large changes in IQ can occur upon retesting. Additional behavioral or clinical corroborative data are needed for valid interpretation of test-retest changes.

Precision Range

Table C-25 in Appendix C shows the 68, 85, 90, 95, and 99 percent confidence intervals for each scale for all age groups and for the average of the nine age groups in the standardization sample. The examinee's specific age group should be used to obtain the most accurate confidence level.

Table 10-2
Test-Retest WAIS-R IQs for Two Groups

		First testing		*Second testing*		
Age	*Scale*	*M IQ*	*SD*	*M IQ*	*SD*	*Change*
25–34 years (*N* = 71)	Verbal IQ	102.0	14.0	105.3	14.3	+3.3
	Performance IQ	103.0	15.6	111.9	17.2	+8.9
	Full Scale IQ	102.4	15.0	109.0	16.8	+6.6
45–54 years (*N* = 48)	Verbal IQ	101.0	14.9	104.1	15.7	+3.1
	Performance IQ	97.3	12.9	105.0	15.6	+7.7
	Full Scale IQ	99.0	13.5	104.7	16.1	+5.7

Source: Adapted from Wechsler (1981).

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VALIDITY

The criterion validity of the WAIS-R has been investigated in a variety of studies by correlating the WAIS-R with the WAIS, WISC-R, Stanford-Binet: Fourth Edition, other intelligence tests, measures of achievement, and years of schooling. Evidence of construct validity has been provided by: (a) the level and pattern of intercorrelations between WAIS-R subtests and scales; (b) the observation that scores on the WAIS-R are distributed in a manner consistent with theoretical expectations; and (c) the results of factor analyses applied to the intercorrelations of the 11 subtests.

WAIS-R and WAIS

A sample of 72 individuals in the 35 to 44 age group of the standardization sample were administered the WAIS-R and WAIS in counterbalanced order within a three- to six-week period (Wechsler, 1981). The correlations between the tests were .91 for the Verbal Scale, .79 for the Performance Scale, and .88 for the Full Scale. For the 11 subtests, correlations ranged from a low of .50 for Picture Arrangement to a high of .91 for Vocabulary (*Mdn* $r = .79$). Subtests on the Verbal Scale have higher correlations (range of .71 to .91, *Mdn* $r = .86$) than do those on the Performance Scale (range of .50 to .85, *Mdn* $r = .66$). The high correlations are not surprising, because most items are the same in both tests. What is less clear is why the correlations are relatively low for some Performance Scale subtests. Shifts in scores on the Performance Scale may be due to practice effects.

For each of the three scales, mean IQs were *lower* on the WAIS-R than on the WAIS. The difference was 6.9 points on the Verbal Scale (101.8 vs. 108.7), 8.0 points on the Performance Scale (105.4 vs. 113.4), and 7.5 points on the Full Scale (103.8 vs. 111.3). These results were based on a small sample of the standardization group (those aged 35 to 44) and should not be generalized to other age groups.

Studies that have compared the WAIS-R and the WAIS within a variety of populations almost uniformly indicate that the WAIS-R provides *lower* scores than does the WAIS (*Mdn* differences = −6.6, −6.4, and −6.8 for the Verbal, Performance, and Full Scale IQs, respectively), but correlations between the two scales are *high* (*Mdn* $r = .94$ for the Verbal Scale, .86 for the Performance Scale, and .94 for the Full Scale) (Edwards & Klein, 1984; Kelly, Montgomery, Felleman, & Webb, 1984; Lewis & Johnson, 1985; Lippold & Claiborn, 1983; Mishra & Brown, 1983; Mitchell, Grandy & Lupo, 1986; Prifitera & Ryan, 1983; Rabourn, 1983; Rogers & Osborne, 1984; Ryan, Rosenberg, & Heilbronner, 1984; Simon & Clopton, 1984; Smith, 1983; Urbina, Golden, & Ariel, 1982; Warner, 1983; Wechsler, 1981). Full Scale IQ differences were larger for persons of average and low average ability (*Mdn* = −8.4) than for those of high average (*Mdn* = −5.3) or superior (*Mdn* = −3.7) ability. In contrast, in a study with mentally retarded subjects, the WAIS-R Verbal (+3.9) and Full Scale (+2.1) IQs were found to be higher than corresponding WAIS values. Thus studies suggest that different relationships may exist between the WAIS-R and the WAIS at different points on the intelligence distribution. Overall, WAIS-R and WAIS IQs are not interchangeable.

In assessing individuals who have received an initial evaluation with the WAIS and are later retested with the WAIS-R, it is important to keep in mind that individuals are likely to obtain lower scores on the WAIS-R. *If the WAIS-R IQ equals or exceeds the previously obtained WAIS IQ, the probability is high that an improvement in cognitive efficiency has occurred. If, however, the WAIS-R IQ is lower than the WAIS IQ, do not infer automatically that intellectual deterioration has occurred.* Consider the extent of the difference. A WAIS-R IQ that is *much* lower than the WAIS IQ may suggest some loss of functioning, but this hypothesis must be supported by clinical data.

WAIS-R and WISC-R

The relationship between the WAIS-R and the WISC-R was discussed in Chapter 6. The research suggests that the WAIS-R yields *slightly higher* IQs than does the WISC-R, particularly with low-functioning individuals. More research is needed on the comparability of the two scales, however.

WAIS-R and Stanford-Binet: Fourth Edition

A sample of 47 normal individuals (*M* age = 19-5) were administered the WAIS-R and Stanford-Binet: Fourth Edition (Thorndike et al., 1986b) within a two-week interval. The mean composite score on the Stanford-Binet: Fourth Edition was 98.7, and the WAIS-R Verbal, Performance, and Full Scale IQs were 100.2, 103.7, and 102.2, respectively. Correlations between the Stanford-Binet and WAIS-R scales were .90 for the Verbal IQ, .85 for the Performance IQ, and .91 for the Full Scale IQ.

In another study, 21 mentally retarded individuals (*M* age = 19-6) were administered the WAIS-R followed by the Stanford-Binet: Fourth Edition, with a median interval of three weeks between the two test administrations

(Thorndike et al., 1986b). The mean Stanford-Binet composite score was 63.8. and the WAIS-R Verbal. Performance, and Full Scale IQs were 74.0. 74.2, and 73.1, respectively. Correlations between the composite score and the Verbal, Performance, and Full Scale IQs were .74, .68, and .79, respectively. Like those for normal subjects, results for retarded individuals suggest that the WAIS-R yields *higher* scores than does the Stanford-Binet: Fourth Edition.

Other Concurrent Validity Studies

Table 10-3 summarizes the results of studies that have correlated the WAIS-R with tests of ability, tests of achievement, and years of formal education (*ability*: Edinger, Shipley, Watkins, & Hammett, 1985; Fowles & Tunick, 1986; Gregg & Hoy, 1985; Heinemann, Harper, Friedman, & Whitney, 1985; Hiltonsmith, Hayman, & Kleinman, 1984; Klett, Watson, & Hoffman, 1986; Kling & Kupersmith, 1984; Maxwell & Wise, 1984; Retzlaff, Slicner, & Gibertini, 1986; Zachary, Crumpton, & Spiegel, 1985; *achievement*: Ryan & Rosenberg, 1983; *formal education*: Matarazzo & Herman, 1984b). The studies indicate that the WAIS-R has satisfactory concurrent validity with intelligence tests, picture vocabulary tests, achievement measures, and years of education. Median correlations shown in Table 10-3 between the various measures and the WAIS-R Full Scale IQ range from .43 to .94.

Construct Validity of the WAIS-R

One way to assess construct validity is to determine whether scores from the WAIS-R conform to the expectations or predictions of a viable theory of intelligence. The Cattell-Horn theory (see Chapter 3) postulates that fluid intelligence involves the ability to solve novel problems and process new material, whereas crystallized intelligence involves the retrieval of well-learned facts. Fluid intelligence is believed to decline with advancing age, whereas crystallized intelligence is said to show little or no age-related deterioration.

The age norms for the 11 WAIS-R subtests indicate that with advancing age verbal ability declines much less than perceptual organization and motor skills (Sattler, 1982a). Corrections for age-related decrements are minimal on the Verbal Scale, with the exception of the Similarities subtest (see Table 10-4). Conversely, marked changes are shown on the Performance Scale subtests, for which additional scaled score points are awarded as a function of age. If the Performance Scale is considered a measure of fluid intelligence and the Verbal Scale a measure of crystallized intelligence, then the WAIS-R age norms are consistent with the Cattell-Horn theory: fluid intelligence, but not crystallized intelligence, shows a marked decrement with advancing age.

Factor analysis can also assist in construct validation because it provides a method for determining the structure and components of intelligence measured by a given test. Factor analysis of the WAIS-R standardization sample indicates that all 11 subtests measure general intelligence (*g*) with a moderate to high degree of success (Blaha & Wallbrown, 1982; Gutkin, Reynolds, & Galvin, 1984; O'Grady, 1983; Parker, 1983; Silverstein, 1982a). These results provide support for interpretation of the Full Scale IQ as a global measure of intelligence. Evidence support-

Table 10-3
Concurrent Validity Studies of the WAIS-R

Criterion	Correlations Verbal IQ	 Performance IQ	 Full Scale I
Wechsler Adult Intelligence Scale[a]	.94	.86	.94
Wechsler Intelligence Scale for Children—Revised[a]	.83	.76	.87
Stanford-Binet: Fourth Edition[a]	.82	.77	.85
Wonderlic Personnel Test	—	—	.75
Henmon-Nelson[b]	.77	.62	.79
Slosson Intelligence Test	.83	.51	.78
Revised Beta Examination	.27	.53	.43
Quick Test[c]	—	—	.75
Shipley-Hartford Scale[b]	.80	.68	.76
Peabody Picture Vocabulary Test	.78	.62	.76
Wide Range Achievement Test (1978) Revision			
Reading	.68	.41	.62
Spelling	.67	.42	.60
Arithmetic	.76	.66	.76
Woodcock-Johnson Tests of Cognitive Ability (Broad Cognitive Cluster Score)	.73	.41	.69
Years of education	.56	.41	.54

[a] Median correlations.
[b] Median correlation for Full Scale only.
[c] Median of Forms 1, 2, and 3.

Table 10-4
Additional Scaled Score Points Awarded on WAIS-R Subtests When the Reference Group Receives a Scaled Score of 10

WAIS-R subtest	*Age group* 35–44	45–54	55–64	65–69	70–74
Verbal Scale					
Information	0	0	0	0	1
Digit Span	0	0	1	1	1
Vocabulary	−1	0	0	0	1
Arithmetic	0	0	1	1	1
Comprehension	0	0	0	1	1
Similarities	1	1	1	2	3
Performance Scale					
Picture Completion	1	1	2	2	4
Picture Arrangement	1	1	2	4	5
Block Design	1	1	2	3	4
Object Assembly	0	1	2	4	4
Digit Symbol	1	2	3	5	6

Note. The results in Table 10-4 indicate that raw scores yielding a scaled score of 10 in the WAIS-R reference group yield, in nearly every case, the same or higher scaled scores in the five age groups over 34 years. The greatest change is at ages 70 to 74 years. For example, in the reference group, a raw score of 57 on Digit Symbol yields a scaled score of 10, but at ages 70 to 74 this same raw score yields a scaled score of 16. The 6 additional scaled-score points awarded at ages 70 to 74 change the percentile for a raw score of 57 from the 50th to the 98th. Digit Symbol exhibits the most change of any WAIS-R subtest, showing a steady increment in scaled-score points from ages 35 to 74.

The greatest changes are consistently shown on the Performance Scale subtests. On the Verbal Scale subtests, the increment in scaled-score points is never greater than 1 point, except for Similarities. For this subtest, two additional scaled-score points are awarded at ages 65 to 69, and three additional scaled-score points are awarded at ages 70 to 74 for a performance that is average in the reference group.

The increments in Table 10-4 actually reflect a *decline* in performance ability. The decline is more graphically revealed when we examine the raw-score points needed at the various age groups to obtain an average scaled score. For example, in the reference group, a Digit Symbol raw score of 57 yields a scaled score of 10. At ages 70 to 74, however, a raw score of only 29 is required to obtain a scaled score of 10. Thus, individuals in the oldest age group need 28 fewer raw-score points than do those in the reference group to obtain average status in their age group.
Source: From J. M. Sattler, "Age effects on Wechsler Adult Intelligence Scale–Revised tests," *Journal of Consulting and Clinical Psychology*, 1982, *50*, p. 786. Copyright 1982 by the American Psychological Association. Reprinted by permission.

ing interpretation of the Verbal and Performance IQs as separate entities is also available (Atkinson & Cyr, 1984; Beck, Horwitz, Seidenberg, Parker, & Frank, 1985; Ryan, Rosenberg, & DeWolfe, 1984; Silverstein, 1982a), although some researchers suggest that the Verbal and Performance IQs do not always constitute the most accurate subdivision of the WAIS-R subtests (see the section on factor analysis later in this chapter). The available research provides substantial support for the construct validity of the WAIS-R.

INTERCORRELATIONS BETWEEN SUBTESTS AND SCALES

The WAIS-R manual provides tables that show the intercorrelations between the 11 subtests and three scales for each of the nine age groups and for the average of the nine age groups. At ages 16 to 17 the subtest intercorrelations range from a low of .21 to a high of .79 (*Mdn* = .43). The six highest subtest intercorrelations are for Vocabulary and Information (.79), Similarities and Vocabulary (.74), Comprehension and Vocabulary (.74), Information and Similarities (.71), Similarities and Comprehension (.66), and Information and Comprehension (.65). The six lowest subtest intercorrelations are for Object Assembly and Digit Symbol (.21), Picture Arrangement and Digit Symbol (.23), Picture Arrangement and Object Assembly (.25), Picture Arrangement and Digit Span (.28), Object Assembly and Arithmetic (.29), and—in a tie—Object Assembly and Information (.30) and Block Design and Picture Arrangement (.30).

The intercorrelations among the six Verbal Scale subtests at ages 16 to 17 range from .36 to .79 (*Mdn* = .61), whereas the intercorrelations among the five Performance Scale subtests range from .21 to .57 (*Mdn* = .36). The Verbal Scale subtests are therefore more highly intercorrelated than are the Performance Scale subtests. Correlations between the 11 subtests and the Full Scale range from a low of .46 (Picture Arrangement and Object Assembly) to a high of .82 (Vocabulary). Five of the six Verbal Scale subtests (Digit Span is the exception) correlate more highly with the Full Scale than do any of the Performance Scale subtests. Of the five Performance Scale subtests, Block Design has the highest correlation with the Full Scale (.67).

The trends observed at ages 16 to 17 are also evident in the intercorrelations based on the average of the nine age groups. Intercorrelations range from .33 to .81 (*Mdn* = .48). The Verbal Scale subtests have higher intercorrelations (.45 to .81, *Mdn* = .61) than do the Performance Scale subtests (.38 to .63, *Mdn* = .47). The Verbal Scale subtests correlate more highly with the Full Scale (.58 to .81, *Mdn* = .75) than do the Performance Scale subtests (.57 to .68, *Mdn* = .61). Vocabul

Table 10-5
Relationship of WAIS-R IQs to Sex, Race, Occupation, Urban-Rural Residence, Geographic Residence, and Years of Education

	Demographic variables	*N*	*Verbal IQ* *M*	*Verbal IQ* *SD*	*Performance IQ* *M*	*Performance IQ* *SD*	*Full Scale IQ* *M*	*Full Scale IQ* *SD*
Sex	Males	940	100.9	15.1	100.6	15.2	100.9	15.3
	Females	940	98.7	14.7	99.2	15.1	98.7	15.0
Race and sex	White males	836	102.3	14.7	102.0	14.7	102.4	14.8
	Black males	93	88.2	13.1	88.0	14.8	87.3	13.6
	White females	828	100.2	14.3	100.8	14.7	100.4	14.6
	Black females	99	87.5	13.2	86.7	12.4	86.4	12.3
Occupation[a]	*Whites*							
	1. Professional and technical	191	112.4	12.1	109.2	14.0	112.2	13.0
	2. Managerial, clerical, sales	378	105.1	11.9	104.2	12.5	105.0	12.0
	3. Craftsmen and foremen	200	98.6	12.0	101.8	13.6	99.5	12.6
	4. Operatives, service workers, farmers	329	94.4	13.2	96.4	14.8	94.8	13.6
	5. Laborers	51	90.6	15.9	93.4	15.2	91.3	15.4
	6. Not in labor force	515	100.8	15.2	100.2	15.0	100.6	15.3
	Blacks							
	1. Professional and technical	10	92.8	9.8	95.5	9.9	93.2	9.4
	2. Managerial, clerical, sales	29	95.4	13.3	92.1	15.6	93.2	[illegible]
	3. Craftsmen and foremen	9	95.7	10.2	93.9	13.4	94.3	[illegible]
	4. Operatives, service workers, farmers	68	85.1	12.7	85.9	13.8	84.6	13.0
	5. Laborers	16	83.8	13.1	83.3	14.5	82.4	13.4
	6. Not in labor force	60	86.5	12.5	85.4	11.5	85.2	11.1
	Total Group							
	1. Professional and technical	206	111.3	12.8	108.4	14.0	111.0	13.4
	2. Managerial, clerical, sales	409	104.3	12.3	103.4	13.1	104.1	12.6
	3. Craftsmen and foremen	213	98.4	11.9	101.3	13.2	99.5	12.6
	4. Operatives, service workers, farmers	404	92.7	13.5	94.5	15.2	93.0	14.1
	5. Laborers	68	88.9	15.3	90.9	15.5	89.0	15.2
	6. Not in labor force	580	99.2	15.5	98.7	15.3	99.9	15.6
Urban-rural residence	Urban	1421	100.4	15.0	100.0	15.1	100.3	15.2
	Rural	459	98.0	14.4	99.4	15.3	98.4	14.9
Geographic residence	Northeast	465	101.7	14.8	101.4	15.0	101.7	15.0
	North Central	497	98.6	14.3	100.2	14.4	99.1	14.2
	South	576	98.6	15.7	97.2	10.2	97.9	16.2
	West	342	101.0	14.3	101.9	14.2	101.5	14.4
Years of education	1. 0-7	133	82.2	13.6	84.5	14.9	82.2	13.6
	2. 8	158	90.2	11.0	93.1	14.2	90.3	12.0
	3. 9-11	472	96.1	13.8	97.8	14.[illegible]	96.4	14.3
	4. 12	652	100.1	12.1	100.2	13.[illegible]	100.1	12.6
	5. 13-15	251	107.7	10.9	105.7	12.[illegible]	107.4	11.1
	6. 16 and up	214	115.7	11.6	111.2	11.[illegible]	15.3	12.3

[a] For ages 16–17 and 18–19, stratification of the samples was according to occupation of head of household.
Source: Adapted from Chastain and Reynolds (1984).

more highly (.81) with the Full Scale than does any other subtest. The subtests with the lowest correlations with the Full Scale are Object Assembly (.57) and Digit Symbol (.57).

WAIS-R IQS AND STRATIFICATION VARIABLES

The relationship of WAIS-R IQs to various stratification variables used in the standardization sample is shown in Table 10-5 (Chastain & Reynolds, 1984). Differences between the mean IQs for males and females on the three scales were less than 3 points. Likewise, less than 3 points separated the IQs for the urban and rural subjects of the normative sample. Slightly larger differences emerged when area of geographic residence was considered, the most sizable one being the 3.8 Full Scale IQ points that separated subjects living in the Northeast (*M* Full Scale IQ = 101.7) from those residing in the South (*M* Full Scale IQ = 97.9). Differences attributed to sex, urban versus rural residence, and geographic location are not large enough to assume any practical significance and, in most cases, may be ignored for interpretive purposes.

Mean IQs show a much clearer relation to race, occupation, and education. For example, white subjects in the standardization sample scored about 15 points higher than black subjects on the Full Scale (101.4 vs. 86.8). The IQs of those employed in professional/technical jobs were 22 points higher on average than those of laborers (111 vs. 89). The most striking difference – 33 points – was between those with less than 8 years of education and those with 16 or more years of education (82 vs. 115). Table 10-6 presents a breakdown of IQs on the three scales according to sex and race for 16- to 17-year-olds. As in the total sample, sex differences are minimal. Race differences are similar to those for the total group.

The correlation between years of school completed and the Full Scale IQ was .54 for the total standardization sample (Matarazzo & Herman, 1984b). There was a progressive increase in mean Full Scale IQ as a function of years of school completed: 8 or fewer years of education, *M* IQ = 86.4; 9–11 years, *M* IQ = 96.4; 12 years, *M* IQ = 100.1; 13–15 years, *M* IQ = 107.4; 16 or more years, *M* IQ = 115.3. Matarazzo and Herman recommend that *when you need a crude estimate of an adult examinee's premorbid (before the onset of disease) WAIS-R IQ, you can use the mean IQ values reported above to arrive at an estimate of such a WAIS-R IQ value. This should be done only when no other estimates are available (such as high school transcripts or test scores).*

FACTOR ANALYSIS

Numerous factor analytic investigations of the WAIS-R have been conducted on the standardization sample (Blaha & Wallbrown, 1982; Glass, 1982; Gutkin et al., 1984; O'Grady, 1983; Parker, 1983; Silverstein, 1982a) as well as on various clinical samples (Atkinson & Cyr, 1984; Faulstich, McAnulty, Gresham, Veitia, Moore, Bernard, Waggoner, & Howell, 1986; Ryan, Prifitera, & Rosenberg, 1983; Ryan, Rosenberg, & DeWolfe, 1984; Ryan & Schneider, 1986). Results of these studies indicate that the WAIS-R may be characterized as either a two- or a three-

Table 10-6
Relationship of WAIS-R IQs to Sex and Race for 16- to 17-Year-Olds

Demographic variables		*N*	*Verbal IQ*		*Performance IQ*		*Full Scale IQ*	
			M	*SD*	*M*	*SD*	*M*	*SD*
Sex	Males	100	100.9	16.0	101.2	15.9	101.1	16.3
	Females	100	99.4	13.6	99.5	14.1	99.2	13.4
Race and sex	White males	85	103.4	14.6	103.8	14.6	103.8	14.3
	Black males	14	86.4	16.9	85.6	15.6	85.4	16.4
	White females	87	100.5	13.2	100.8	13.3	100.4	12.8
	Black females	12	90.5	13.9	88.0	12.8	88.7	13.1

Source: Adapted from Chastain and Reynolds (1984).

factor battery. A three-factor solution is useful for clinical and psychoeducational tasks, but when individual protocols are being interpreted, any hypotheses based on factor analytic findings should be supplemented with clinical judgment.

The three WAIS-R factors are similar to those on the WISC-R – namely, Verbal Comprehension (Information, Vocabulary, Comprehension, and Similarities), Perceptual Organization (Picture Completion [except at 18–19 years], Block Design, and Object Assembly), and Freedom from Distractibility (Digit Span and Arithmetic) (see Table 10-7). The subtests comprising the factors, however, differ somewhat for the two scales. Coding loads on the Freedom from Distractibility factor on the WISC-R, but its counterpart on the WAIS-R, Digit Symbol, does not. Similarly, Picture Arrangement is one of the subtests in the Perceptual Organization factor on the WISC-R, but not on the WAIS-R. There is no simple explanation for these findings. (All factor analytic findings presented in Table 10-7 and below are based on work by the chapter authors.)

WAIS-R Subtests as Measures of *g*

As shown in Table 10-8, all of the WAIS-R subtests are either good or fair measures of *g* (the general intelligence factor). Based on the average of the nine age levels, the subtests with the highest *g* loadings are Vocabulary (.86), Information (.81), Similarities (.79), Comprehension (.78), Arithmetic (.75), and Block Design (.72). The subtests with fair *g* loadings are Picture Completion (.70), Picture Arrangement (.63), Digit Span (.62), Object Assembly (.61), and Digit Symbol (.59). Overall, the Verbal subtests are better measures of *g* than are the Performance subtests.

Subtest Specificity

Subtest specificity refers to the proportion of a subtest's variance that is both reliable (that is, not due to errors of measurement) and distinctive to the subtest. Although individual subtests overlap in their measurement properties (that is, the majority of reliable variance for most subtests is common factor variance), many of them possess a relatively high degree of specificity, which justifies interpretation of specific subtest functions (see Table 10-9). Some subtests have either ample or adequate specificity throughout the entire age range covered by the WAIS-R (Digit Span, Vocabulary, Picture Completion, Block Design, and Digit Symbol), whereas others have inadequate specificity at one or more ages (Information, Arithmetic, Comprehension, Similarities, Picture Arrangement, and Object Assembly). Subtests with inadequate specificity should not be interpreted as measuring specific functions, and cautious interpretation is required for subtests falling within the adequate specificity category. These subtests can be interpreted as measuring *g* and the appropriate principal factor, however (Verbal Comprehension, Perceptual Organization, and Freedom from Distractibility, respectively).

Factor Scores

Factor scores can be obtained from the WAIS-R, permitting the identification of meaningful psychological dimensions. The Verbal Comprehension factor score measures verbal knowledge and understanding obtained by formal and informal education and reflects the ability to apply verbal skills to new situations. The Perceptual Organization factor score reflects the ability to interpret and organize visually perceived material while working against a time limit. The Freedom from Distractibility factor score measures the ability to attend or concentrate, but also may involve numerical proficiency and sequencing skills. These factor scores are discussed more fully in Chapter 8.

The preferred way to obtain the three factor scores is to use the following combinations of subtests:

Verbal Comprehension = Sum of age-corrected scaled scores on Information, Vocabulary, Comprehension, and Similarities at all ages

Perceptual Organization = Sum of age-corrected scaled scores on Block Design, Object Assembly, and Picture Completion at every age level (except 18–19, where the last subtest should be omitted from the factor score)

Freedom from Distractibility = Sum of age-corrected scaled scores on Digit Span and Arithmetic

The sums of the respective age-corrected subtest scaled scores comprising the three factors can be converted into Deviation IQs ($M = 100$, $SD = 15$). Table C-28 in Appen-

Table 10-7
WAIS-R Subtest Loadings on Factor A (Verbal Comprehension), Factor B (Perceptual Organization), and Factor C (Freedom from Distractibility) for Nine Age Levels and the Average Following Varimax Rotation

	Age group									
WAIS-R subtest	*16–17*	*18–19*	*20–24*	*25–34*	*35–44*	*45–54*	*55–64*	*65–69*	*70–74*	*Av.*
				Factor A – Verbal Comprehension						
Information	78	80	77	67	62	70	76	78	76	75
Digit Span	22	46	28	36	36	54	27	30	38	30
Vocabulary	81	83	83	77	80	86	87	75	83	81
Arithmetic	54	58	40	43	41	56	45	45	41	44
Comprehension	69	66	69	71	72	69	71	82	68	71
Similarities	78	67	68	60	68	65	70	67	63	67
Picture Completion	40	26	45	46	45	36	49	38	38	44
Picture Arrangement	37	36	52	48	44	37	45	40	26	42
Block Design	29	19	21	27	31	27	27	31	30	27
Object Assembly	18	16	25	20	23	21	16	17	12	19
Digit Symbol	38	37	11	42	31	44	41	41	24	32
				Factor B – Perceptual Organization						
	20	21	18	30	28	32	28	31	20	21
	23	31	11	19	17	34	37	26	31	22
Vocabulary	31	21	20	28	24	21	14	33	31	26
Arithmetic	25	53	27	30	42	49	44	36	22	34
Comprehension	33	19	31	26	26	20	36	26	33	30
Similarities	25	30	30	38	31	29	46	41	46	36
Picture Completion	46	19	59	64	43	41	57	66	51	56
Picture Arrangement	24	21	33	44	32	33	48	48	54	42
Block Design	79	77	67	67	64	74	72	74	75	69
Object Assembly	60	48	67	78	88	71	65	76	75	73
Digit Symbol	23	52	26	24	25	45	41	55	55	38
				Factor C – Freedom from Distractibility						
Information	28	25	26	44	48	38	21	25	33	30
Digit Span	74	09	63	53	63	10	56	68	42	64
Vocabulary	27	31	29	40	40	32	37	41	26	34
Arithmetic	49	15	63	63	55	15	49	53	47	55
Comprehension	22	41	25	32	32	35	27	23	26	27
Similarities	18	27	24	26	33	36	11	31	20	27
Picture Completion	20	67	12	18	35	62	10	25	34	17
Picture Arrangement	18	41	17	22	48	51	20	34	18	23
Block Design	26	25	35	46	42	31	31	19	28	33
Object Assembly	14	47	23	16	18	27	26	21	09	17
Digit Symbol	39	17	49	26	53	14	19	38	09	36

Note. Av. = average. Decimal points omitted. According to Parker (1983), Digit Span and Arithmetic should be included in the Freedom from Distractibility factor at ages 18–19 and 45–54 because these subtests have high loadings on this factor in a four-factor solution.

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Table 10-8
WAIS-R Subtests as Measures of *g*

Good measure of g			*Fair measure of g*		
Subtest	*Median g loading*	*Proportion of variance attributed to g (%)*	*Subtest*	*Median g loading*	*Proportion of variance attributed to g (%)*
Vocabulary	.87	76	Picture Completion	.71	50
Information	.82	67	Picture Arrangement	.67	45
Similarities	.79	62	Object Assembly	.63	40
Comprehension	.78	61	Digit Span	.62	38
Arithmetic	.76	58	Digit Symbol	.60	36
Block Design	.73	53			

Note. These are median loadings based on the nine age groups in the standardization sample. The square of the median coefficients provides the proportion of each subtest's variance that may be attributed to *g*.

dix C provides for a rapid conversion of the three factor scores into Deviation IQs for ages 16 to 17 and for the average of the nine age groups.

ADMINISTERING THE WAIS-R

The general procedures discussed in Chapter 5 for administering psychological tests are also useful in administering the WAIS-R, as are the guidelines in Chapters 6 and 7 for administering the WISC-R. Be careful not to confuse the administration procedures of the WISC-R with those of the WAIS-R, however – different instructions and time limits are used on some subtests of the same name. The general problems in administering the WISC-R also apply to the WAIS-R. The suggestions shown in Exhibit 10-1 should aid you in learning how to administer the WAIS-R. (Figure 10-1 shows the cover of the WAIS-R record booklet.)

Physical Abilities Required for the WAIS-R

Adequate hearing and language functions are required for the Verbal Scale subtests, and adequate vision and visual-motor ability are needed for the Performance Scale subtests. The suggestions presented in Chapters 6 and 7 for administering the WISC-R to handicapped examinees (see particularly Table 6-11) should be carefully studied.

Subtest Sequence

In most situations subtests should be administered in the standard sequence, as specified in the WAIS-R manual. If warranted, however, all of the Verbal subtests can be administered first followed by the Performance subtests. This order may be less stressful for examinees who have minor motor problems that may interfere with the Performance subtests. It is also permissible to adjust the order of administration for examinees who fatigue easily (for example, the elderly or physically ill) or display marked anxiety about the testing situation. Examinees who fatigue easily may be given certain subtests (for example, Arithmetic, Digit Span, or Digit Symbol) early in the session when their energy levels and attention-concentration skills are best. Anxious examinees may be started with subtests that are relatively nonthreatening and do not have strict time limits (for example, Information, Comprehension, or Vocabulary).

Some examinees with psychiatric or neurological disorders may not be able to complete the entire WAIS-R in a single session. In such cases, schedule breaks to coincide with the end of a subtest so that testing can easily be resumed at a later time. In the rare instances where a subtest must be interrupted prior to completion, resume administration of the subtest where you stopped except on Similarities, Block Design, and Picture Arrangement. On these subtests, the easy items provide some examinees with the practice they need to succeed at more difficult items. Therefore, if Similarities, Block Design or Picture Arrangement is interrupted, the first few items should be

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Table 10-9
Amount of Specificity for WAIS-R Subtests

	Ample specificity	*Adequate specificity*	*Inadequate specificity*
WAIS-R subtest	*Ages*	*Ages*	*Ages*
Information	—	16–44, 55–74, Average	45–54
Digit Span	16–74, Average	—	—
Vocabulary	—	16–74, Average	—
Arithmetic	20–34, 45–74, Average	18–19, 35–44	16–17
Comprehension	45–54	25–44, 65–74, Average	16–24, 55–64
Similarities	25–34	18–19, 35–74, Average	16–17, 20–24
Picture Completion	16–74, Average	—	—
Picture Arrangement	16–19, 25–64, 70–74, Average	—	20–24, 65–69
Block Design	16–34, 55–69, Average	35–54, 70–74	—
Object Assembly	18–19	—	16–17, 20–74, Average
Digit Symbol	16–64, 70–74, Average	65–69	—

repeated at the next session so that the examinee can reestablish the mental set necessary to succeed on the harder items. Naturally, you must consider how any administrative irregularity will affect the accuracy of the test results.

Starting Rules

Eight of the 11 subtests are started with the first item. The remaining three subtests (Information, Vocabulary, and Arithmetic) are started with the fifth, fourth, and third items, respectively. On these three subtests, score the entry-point items as soon as they are administered. Credit is automatically given for the unadministered early items when the entry-point items (the first two, three, or four items administered) are answered correctly. If the entry-point items are answered incorrectly, it is necessary to administer the earlier items before continuing the subtest.

Discontinuance Rules

Nine of the 11 subtests have discontinuance rules – the subtest is discontinued after a specified number of consecutive items are failed. (Object Assembly and Digit Symbol are the two subtests without discontinuance rules.) If you administer additional items in a subtest because you are not sure whether the items at the discontinuance point were failed, use the following rule to score the additional items (Wechsler, 1981, p. 54): *If subsequent scoring of the items indicates that the additional items were administered unnecessarily, do not give credit for any items passed after the discontinuance point.* This rule, which is also followed in the WISC-R, helps to maintain standardized procedures.

Repetition of Items

Use judgment in deciding when to repeat questions. The Digit Span items are the only verbal items that *cannot* be repeated.

Use of Probing Questions and Queries

Use probing questions when responses are ambiguous, vague, or indefinite, or when probing is indicated by a "(Q)" in the various scoring criteria appendices in the WAIS-R manual.

Testing-of-Limits Procedures

Use modifications in test procedures designed for testing-of-limits only *after* all of the subtests have been administered according to standardized procedures

Scoring WAIS-R Responses

Arriving at accurate scores for WAIS-R subtests and scales is no simple matter. Scoring errors can have a significant impact on the accuracy of WAIS-R IQs. A study indicated that graduate students and experienced psychologists differed by 4 to 18 IQ points in the scores they gave to two

Exhibit 10-1

Supplementary Instructions for Administering the WAIS-R

1. Complete the top of the record booklet.

2. Calculate the chronological age (CA) and put it in the box provided.

3. Administer the subtests in the order presented in the WAIS-R manual, except in rare circumstances. Do not change the wording on any subtest. Read the directions and material from the manual. Do not ad lib.

4. Start with the appropriate item on each subtest and follow discontinuance criteria. This means that you must know the scoring criteria before you administer the scale.

5. Write out all responses completely and legibly. Do not use unusual abbreviations. Record time accurately.

6. Question all ambiguous or unscorable responses, using the words suggested in the WAIS-R manual for questioning. You may need to question on Information, Vocabulary, Comprehension, and Similarities. Whenever you ask a question, write (Q) after the questioned response.

7. Carefully score each protocol, recheck scoring, and transfer subtest scores to the front of the record booklet under Raw Score. If you have failed to question a response when you should have and the response is obviously not a 0 response, give the examinee the most appropriate score.

8. If a subtest was spoiled, write *spoiled* by the subtest total score and on the front cover where the raw scores and scaled scores appear. If for some reason a subtest was not administered, write *NA* in the margin in the record booklet and on the front cover.

9. Raw scores are transformed into scaled scores through use of the table on the front of the record booklet (or Table 19 on page 90 of the WAIS-R manual). Be sure to use the correct row and column for each transformation.

10. The Verbal score is based on the total of the scaled scores on the six Verbal Scale subtests. The Performance score is based on the total of the scaled scores on the five Performance Scale subtests. Add the Verbal score and the Performance score to get the Full Scale score.

11. If it should be necessary to prorate either the Verbal or Performance section, follow the explicit directions given on page 88 of the WAIS-R manual.

12. The IQs are obtained from Table 20 (pages 92 through 109) of the WAIS-R manual. There is a Verbal section, a Performance section, and a Full Scale section. Be sure to use the correct section of the table for each of the three IQs. Record the IQs. Next, recheck all of your work. If any IQs were prorated, write *PRO* beside the appropriate IQs.

13. If you want to compare the examinee to the reference group, make a profile of the examinee's scaled scores on the record booklet. A profile of age-corrected scaled scores can also be made.

14. Look up the confidence intervals for the Full Scale IQ, Verbal Scale IQ, and Performance Scale IQ in Table C-25 in Appendix C.

15. Look up the percentile rank and classification for each of the IQs in Tables BC-1 and BC-2 on the inside back cover of this text.

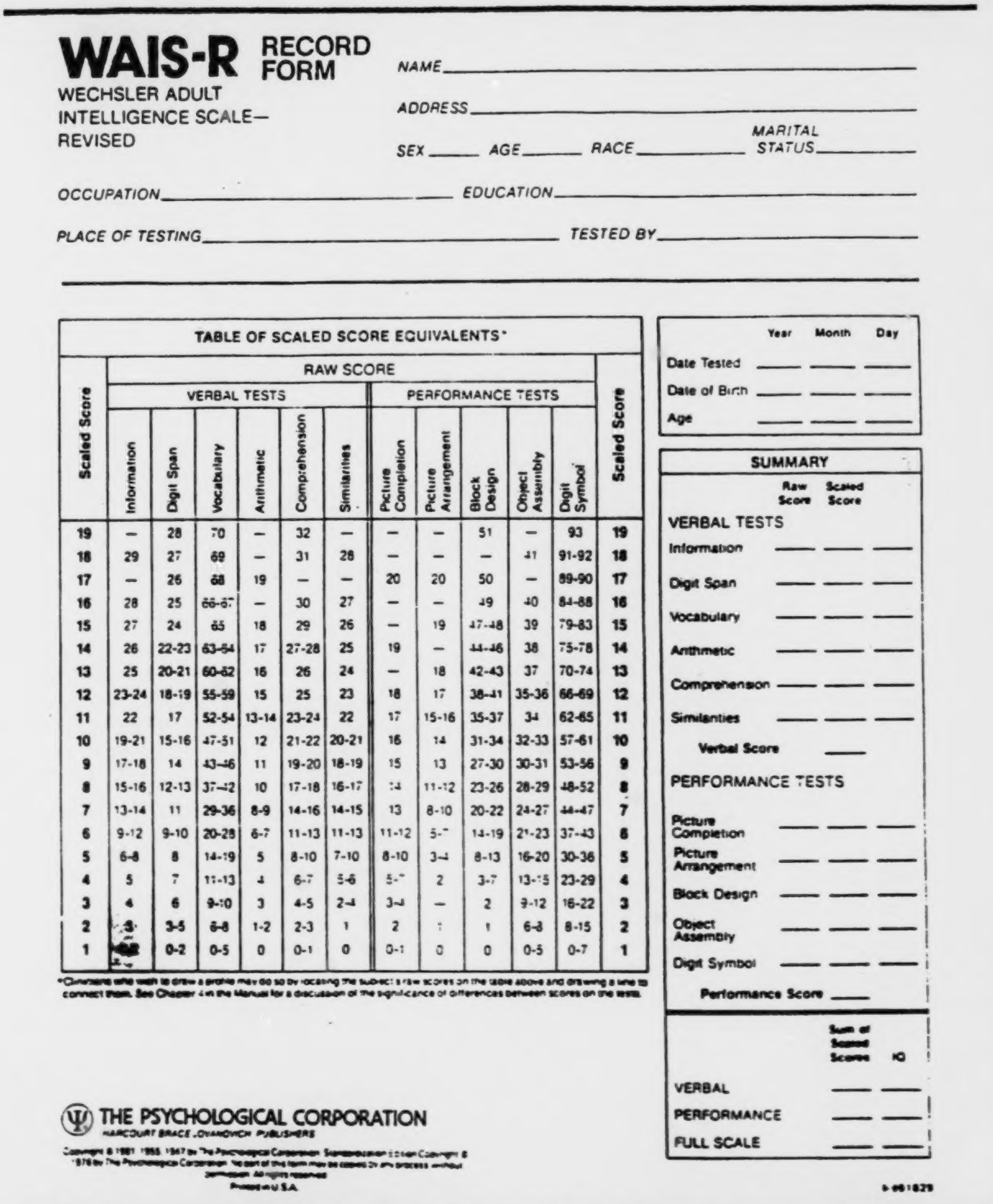
Source: Courtesy of M. L. Lewis.

WAIS-R protocols (Ryan, Prifitera, & Powers, 1983). Additionally, both groups of raters converted scaled scores to IQs incorrectly, gave credit for individual items incorrectly, and added raw scores incorrectly. In another study additional scoring problems included failing to credit responses that appeared in the manual and assigning credit for symbol pairings on Digit Symbol incorrectly (Franklin et al., 1982). Obviously, you should guard against making such errors.

Judgment is important in scoring WAIS-R responses, especially when ambiguous responses are encountered on the Vocabulary, Comprehension, and Similarities subtests. Carefully study the scoring criteria, scoring guidelines, and scoring examples in the WAIS-R manual.

Extrapolated IQs

Because the lowest scaled score is 1 point, the sum of scaled scores cannot be lower than 6 for the Verbal Scale or 5 for the Performance Scale when proration procedures are used. Consequently, the minimum sum of scaled scores is shown in the WAIS-R manual. When the sum of scaled scores is higher than the highest sum shown in Table 20 of the WAIS-R manual, report the IQ as "over 150" (Wechsler, 1981). In some cases, however, you can extrapolate the IQ. Table C-30 in Appendix C extends the sum of scaled scores and IQs up to the maximum possible sum of scaled scores for the Verbal, Performance, and Full Scales separately for each of the nine age groups. As noted in Chapter 6, extrapolated IQs must be used cautiously.



WAIS-R RECORD FORM

WECHSLER ADULT
INTELLIGENCE SCALE—
REVISED

NAME ____________________

ADDRESS ____________________

SEX ______ AGE ______ RACE ______ MARITAL STATUS ______

OCCUPATION ____________________ EDUCATION ____________________

PLACE OF TESTING ____________________ TESTED BY ____________________

TABLE OF SCALED SCORE EQUIVALENTS*

	RAW SCORE											
	VERBAL TESTS						PERFORMANCE TESTS					
Scaled Score	Information	Digit Span	Vocabulary	Arithmetic	Comprehension	Similarities	Picture Completion	Picture Arrangement	Block Design	Object Assembly	Digit Symbol	Scaled Score
19	—	28	70	—	32	—	—	—	51	—	93	19
18	29	27	69	—	31	28	—	—	—	41	91-92	18
17	—	26	68	19	—	—	20	20	50	—	89-90	17
16	28	25	66-67	—	30	27	—	—	49	40	84-88	16
15	27	24	65	18	29	26	—	19	47-48	39	79-83	15
14	26	22-23	63-64	17	27-28	25	19	—	44-46	38	75-78	14
13	25	20-21	60-62	16	26	24	—	18	42-43	37	70-74	13
12	23-24	18-19	55-59	15	25	23	18	17	38-41	35-36	66-69	12
11	22	17	52-54	13-14	23-24	22	17	15-16	35-37	34	62-65	11
10	19-21	15-16	47-51	12	21-22	20-21	16	14	31-34	32-33	57-61	10
9	17-18	14	43-46	11	19-20	18-19	15	13	27-30	30-31	53-56	9
8	15-16	12-13	37-42	10	17-18	16-17	14	11-12	23-26	28-29	48-52	8
7	13-14	11	29-36	8-9	14-16	14-15	13	8-10	20-22	24-27	44-47	7
6	9-12	9-10	20-28	6-7	11-13	11-13	11-12	5-7	14-19	21-23	37-43	6
5	6-8	8	14-19	5	8-10	7-10	8-10	3-4	8-13	16-20	30-36	5
4	5	7	11-13	4	6-7	5-6	5-7	2	3-7	13-15	23-29	4
3	4	6	9-10	3	4-5	2-4	3-4	—	2	9-12	16-22	3
2	3	3-5	6-8	1-2	2-3	1	2	1	1	6-8	8-15	2
1	[illegible]	0-2	0-5	0	0-1	0	0-1	0	0	0-5	0-7	1

*Clinicians who wish to draw a profile may do so by locating the subject's raw scores on the table above and drawing a line to connect them. See Chapter 4 in the Manual for a discussion of the significance of differences between scores on the tests.

	Year	Month	Day
Date Tested	____	____	____
Date of Birth	____	____	____
Age	____	____	____

SUMMARY

	Raw Score	Scaled Score	
VERBAL TESTS			
Information	____	____	____
Digit Span	____	____	____
Vocabulary	____	____	____
Arithmetic	____	____	____
Comprehension	____	____	____
Similarities	____	____	____
Verbal Score		____	
PERFORMANCE TESTS			
Picture Completion	____	____	____
Picture Arrangement	____	____	____
Block Design	____	____	____
Object Assembly	____	____	____
Digit Symbol	____	____	____
Performance Score		____	

	Sum of Scaled Scores	IQ
VERBAL	____	____
PERFORMANCE	____	____
FULL SCALE	____	____

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9-061829

Figure 10-1. Cover page of WAIS-R record booklet. Copyright © 1981, 1955, 1947 by The Psychological Corporation. San Antonio, TX. All rights reserved.

WAIS-R SHORT FORMS

Short forms of the WAIS-R have the same advantages and disadvantages as do short forms of the WISC-R. Chapter 6 thoroughly discusses the use of short forms; review this material as needed.

Selecting the Short Forms

Table C-34 in Appendix C provides the 10 best short form combinations of two, three, four, and five WAIS-R subtests. For all practical purposes, the short forms of a given length are mutually interchangeable in terms of psychometric properties. The choice of a short form should be based on the considerations discussed in Chapter 6.

After the short form has been selected, follow the procedures outlined in Chapter 6 (see Exhibit 6-3) to convert the composite scores to Deviation Quotients. Use Table C-36 in Appendix C to obtain the appropriate *a* and *b* constants. To obtain r_{jk}, use the section of the WAIS-R correlation table (Table 15) that corresponds to the examinee's age group.

Satz-Mogel Abbreviated Procedure

The Yudin short form procedure, which reduces the number of items within subtests, is known as the Satz-Mogel short form when applied to the WAIS-R (Satz & Mogel, 1962). Table C-35 in Appendix C shows the specific procedures for obtaining this WAIS-R short form. Validity coefficients and standard errors of measurement, based on the entire standardization sample, are .94 and ±5.1 for the Verbal IQ, .89 and ±6.8 for the Performance IQ, and .95 and ±4.7 for the Full Scale IQ, respectively (Silverstein, 1982d). Although the Satz-Mogel approach is a useful screening device for estimating the Full Scale IQ, it should not be used to interpret individual subtest scores. Poor correlations have been reported between estimated subtest scaled scores and actual obtained scores. Additionally, estimated scaled scores have been found to exceed the range of ±2 scaled score points from actual obtained scores in over 25 percent of 81 cases studied (Evans, 1985).

Vocabulary plus Block Design Short Form

A two-subtest combination that is popular as a short form screening instrument is Vocabulary plus Block Design. These two subtests have moderate (Block Design) and high (Vocabulary) correlations with the Full Scale, have consistently high reliabilities, and are good measures of *g*. If this combination is chosen, Table C-37 in Appendix C can be used to convert the sum of *age-corrected scaled scores* directly into an estimated Full Scale IQ (Brooker & Cyr, 1986). The reliability of the composite is impressive (r_{xx} = .94 for the average of nine age groups) with an SE_m in IQ points of 3.58 for 16- to 17-year-olds and 3.64 for the average of all nine age groups (Silverstein, 1985b). The Vocabulary plus Block Design short form consistently overestimates the average Full Scale IQ of clinical samples by approximately 3 points, however (Margolis, Taylor, & Greenlief, 1986; Roth, Hughes, Monkowski, & Crosson, 1984; Ryan, Larsen, & Prifitera, 1983; Thompson, Howard, & Anderson, 1986).

Vocabulary, Block Design, and Information

A useful three-subtest short form is Vocabulary, Block Design, and Information. Table C-38 in Appendix C can be used to convert the sum of the three *age-corrected subtest scaled scores* into an estimated Full Scale IQ.

Vocabulary, Block Design, Arithmetic, and Similarities

A useful four-subtest short form is Vocabulary, Block Design, Arithmetic, and Similarities. Table C-39 in Appendix C can be used to convert the sum of the four *age-corrected subtest scaled scores* into an estimated Full Scale IQ.

Information, Arithmetic, Picture Completion, and Block Design Short Form

Another potentially useful short form combination is Information, Arithmetic, Picture Completion, and Block Design (Reynolds, Willson, & Clark, 1983). Table C-40 in Appendix C can be used to convert the sum of the four *age-corrected subtest scaled scores* into an estimated Full Scale IQ. The reliability of the composite is adequate (r_{xx} = .88 for the average of nine age groups), and estimated stability over time is excellent (.95 for 71 standardization subjects between 25 and 34 years of age; .96 for 48 standardization subjects between 45 and 54 years of age). The SE_m in IQ points is 5.73 for 16- to 17-year-olds, and 5.26 for the average of the nine age groups in the standardization sample. This four-subtest short form is a valid predictor of the Full Scale IQ in normal subjects (Reynolds et al., 1983) and neurologically impaired patients (Ryan, 1985)

WAIS-R SUBTESTS

Information

The Information subtest contains 29 questions which sample a broad range of general knowledge, including literary, historical, and geographical facts and dates. All examinees start with item 5. All items are scored 1 or 0 (pass-fail), and the subtest is discontinued after five consecutive failures. The questions usually can be answered with a simply stated fact. The examinee is not required to find relationships between facts in order to receive credit.

Rationale. The rationale presented for the WISC-R Information subtest applies to the WAIS-R Information subtest (see Chapter 7).

Factor analytic findings. Information is the second-best measure of *g* in the scale (67 percent of its variance may be attributed to *g*). It has adequate subtest specificity in every age range with the exception of 45 to 54 years, where its specificity is inadequate. Information contributes substantially to the Verbal Comprehension factor (*Mdn* loading = .76).

Reliability and correlational highlights. Information is a reliable subtest (r_{xx} = .89). It correlates more highly with Vocabulary (*r* = .81) than with any other subtest. It correlates moderately with the Full Scale IQ (*r* = .76), the Verbal Scale IQ (*r* = .79), and the Performance Scale IQ (*r* = .62).

Administrative and interpretive considerations. The administrative and interpretive considerations presented for the WISC-R Information subtest are also relevant for the WAIS-R (see Chapter 7).

Digit Span

The Digit Span subtest has two parts: Digits Forward, which contains series ranging in length from three to nine digits, and Digits Backward, which contains series ranging in length from two to eight digits. The examinee listens to a sequence of digits given orally by the examiner and then repeats the digits. There are two sets of digits of each length. Digits Forward is administered first, followed by Digits Backward. On the WAIS-R Digit Span is a regular subtest, whereas on the WISC-R it is supplementary.

All series are scored 2, 1, or 0. On both parts of the subtest, testing is discontinued after failure on both trials of any series. Scaled scores and age-corrected scores are not provided separately for Digits Forward and Digits Backward.

Rationale. The rationale presented for the WISC-R Digit Span subtest applies to the WAIS-R Digit Span subtest (see Chapter 7).

Factor analytic findings. The Digit Span subtest is a fair measure of *g* (38 percent of its variance may be attributed to *g*). It has ample subtest specificity across the entire age range to permit specific interpretation of its functions. Digit Span has a high loading on the Freedom from Distractibility factor (*Mdn* loading = .56).

Reliability and correlational highlights. Digit Span is a reliable subtest (r_{xx} = .83). It correlates more highly with Arithmetic (*r* = .56) and Vocabulary (*r* = .52) than with the remaining subtests. It has a relatively low correlation with the Full Scale IQ (*r* = .58), the Verbal Scale IQ (*r* = .57), and the Performance Scale IQ (*r* = .50).

Administrative and interpretive considerations. The administrative and interpretive considerations presented for the WISC-R Digit Span subtest are also relevant for the WAIS-R (see Chapter 7).

Vocabulary

The Vocabulary subtest contains 35 words arranged in order of increasing difficulty. Each word is presented orally and in writing, and the examinee is asked to explain aloud its meaning. All examinees start with the fourth word, except those who seem to have poor verbal ability. Each word is scored 2, 1, or 0, and the subtest is discontinued after five consecutive failures.

Rationale. The rationale presented for the WISC-R Vocabulary subtest applies to the WAIS-R Vocabulary subtest (see Chapter 7).

Factor analytic findings. The Vocabulary subtest is the best measure of *g* in the scale (76 percent of its variance may be attributed to *g*). The subtest has an adequate amount of subtest specificity across the entire age range and contributes substantially to the Verbal Comprehension factor (*Mdn* loading = .83).

Reliability and correlational highlights. Vocabulary is the most reliable subtest in the scale (r_{xx} = .96). It correlates more highly with Information (*r* = .81) than with any other subtest. It has high correlations with the Full Scale IQ (*r* = .81) and the Verbal Scale IQ (*r* = .85) and a moderate correlation with the Performance Scale IQ (*r* = .65).

Administrative and interpretive considerations. The administrative and interpretive considerations presented for the WISC-R Vocabulary subtest generally apply to the WAIS-R (see Chapter 7). On the WAIS-R Vocabulary subtest, however, the examinee looks at a word list as the examiner pronounces each word. Also, when the examinee gives a 0- or 1-point definition on the first word, no help is provided by the examiner.

Study carefully the "Sample Responses" section of Appendix A of the WAIS-R manual so that you will know which responses require further inquiry, indicated by "(Q)." The examples indicate that many 0- and 1-point responses should be queried. When a 2-point response is accompanied by a "(Q)," it is the entire response including the elaboration that is worth 2 points.

Arithmetic

The Arithmetic subtest contains 14 problems: 13 are given orally and the other one involves blocks. All examinees start with item 3. All problems are timed, with items 1 through 4 having a time limit of 15 seconds; items 5 through 9, 30 seconds; items 10 through 13, 60 seconds; and item 14, 120 seconds. All items are scored 1 or 0, with up to 2 additional time-bonus points possible on items 10 through 14.

Rationale. The rationale presented for the WISC-R Arithmetic subtest applies to the WAIS-R Arithmetic subtest (see Chapter 7).

Factor analytic findings. Arithmetic is a good measure of *g* (58 percent of its variance may be attributed to *g*). The subtest has ample subtest specificity to permit interpretation of its functions at ages 20 to 34 years and 45 to 74 years. It has only adequate specificity at ages 18 to 19 years and 35 to 44 years, and it has inadequate specificity at ages 16 and 17 years. Arithmetic has a high loading on the Freedom from Distractibility factor (*Mdn* loading = .53) and a moderate loading on the Verbal Comprehension factor (*Mdn* loading = .45).

Reliability and correlational highlights. Arithmetic is a reliable subtest (r_{xx} = .84). It correlates best with Vocabulary (*r* = .63) and Information (*r* = .61). It correlates moderately with the Full Scale IQ (*r* = .72), the Verbal Scale IQ (*r* = .70), and the Performance Scale IQ (*r* = .62).

Administrative and interpretive considerations. The administrative and interpretive considerations discussed for the WISC-R Arithmetic subtest generally apply to the WAIS-R (see Chapter 7). A booklet is not used to present any of the WAIS-R items to the examinee, however.

Comprehension

The Comprehension subtest contains 16 questions covering a wide range of situations and proverbs. Questions deal with such issues as government operations and laws, health standards, and social mores. All examinees begin the subtest with item 1, and all items are scored 2, 1, or 0. The subtest is discontinued after four consecutive failures.

Rationale. The rationale presented for the WISC-R Comprehension subtest applies to the WAIS-R Comprehension subtest (see Chapter 7).

Factor analytic findings. The Comprehension subtest is a good measure of *g* (61 percent of its variance may be attributed to *g*). Subtest specificity varies with age. There is ample specificity at ages 45 to 54, adequate specificity at ages 25 to 44 and 65 to 74, and inadequate specificity at ages 16 to 24 and 55 to 64. Consequently, specific interpretation of the subtest's functions is appropriate only at some ages. The Comprehension subtest has a high loading on the Verbal Comprehension factor (*Mdn* loading = .69).

Reliability and correlational highlights. Comprehension is a reliable subtest (r_{xx} = .84). It correlates more highly with Vocabulary (*r* = .74), Information (*r* = .58), and Similarities (*r* = .68) than with any other subtests. It correlates moderately with the Full Scale IQ (*r* = .74), the Verbal Scale IQ (*r* = .76), and the Performance Scale IQ (*r* = .61).

Administrative and interpretive considerations. Administrative and interpretive considerations presented for the WISC-R Comprehension subtest are also relevant to the WAIS-R. Study carefully the "Sample Responses" section of Appendix B of the WAIS-R [illegible] that you will know which responses require further inquiry, indicated by "(Q)." The examples indicate that some 0- and 1-point responses should be queried.

Similarities

The Similarities subtest contains 14 pairs of words; the examinee is asked to explain the similarity between the two words in each pair. All examinees start with the first item. All items are scored 2, 1, or 0, depending on the conceptual level of the response. The subtest is discontinued after four consecutive failures.

Rationale. The rationale described for the WISC-R Similarities subtest applies to the WAIS-R Similarities subtest (see Chapter 7).

Factor analytic findings. Similarities is the third-best measure of *g* in the scale (62 percent of its variance may be attributed to *g*). The subtest has ample subtest specificity at ages 25 to 34, adequate specificity at ages 18 to 19 and 35 to 74, and inadequate specificity at ages 16 to 17 and 20 to 24. Specific interpretation of the subtest's functions is inappropriate at ages 16 to 17 and 20 to 24. Similarities contributes substantially to the Verbal Comprehension factor (*Mdn* loading = .67).

Reliability and correlational highlights. Similarities is a reliable subtest (r_{xx} = .84). It correlates best with Vocabulary (r = .72) and Comprehension (r = .68). It correlates moderately with the Full Scale IQ (r = .75), the Verbal Scale IQ (r = .74), and the Performance Scale IQ (r = .64).

Administrative and interpretive considerations. Most of the administrative and interpretive considerations presented for the WISC-R Similarities subtest apply to the WAIS-R (see Chapter 7). The major difference is that on the WAIS-R all items are scored 2, 1, or 0, whereas on the WISC-R a 2 may be given only on items 5 to 17. Considerable skill is required to score Similarities responses.

Appendix C in the WAIS-R manual merits careful study. First, the general scoring principles, which give the rationale for scores of 2, 1, and 0, should be thoroughly mastered. Second, the sample responses section should be studied carefully so that responses that should be queried, indicated by "(Q)," can be recognized readily.

Picture Completion

The Picture Completion subtest consists of 20 drawings of common objects (such as a door, a boat, and a leaf), each of which lacks a single essential element. The examinee's task is to name or point to the missing portion of the picture. There is a 20-second time limit for each picture. All examinees start with the first item. Each item is scored 1 or 0 (pass-fail), and the subtest is discontinued after five consecutive failures.

Rationale. The rationale described for the WISC-R Picture Completion subtest applies to the WAIS-R Picture Completion subtest (see Chapter 7).

Factor analytic findings. The Picture Completion subtest is a fair measure of *g* (50 percent of its variance may be attributed to *g*). The subtest has ample specificity at all ages to permit specific interpretation of its functions. Picture Completion contributes substantially to the Perceptual Organization factor at all the age levels except 18 to 19 (*Mdn* loading = .51).

Reliability and correlational highlights. Picture Completion is a reliable subtest (r_{xx} = .81). It correlates more highly with Vocabulary (r = .55) than with any other subtest. It correlates moderately with the Full Scale IQ (r = .67), the Performance Scale IQ (r = .65), and the Verbal Scale IQ (r = .61).

Administrative and interpretive considerations. The administrative and interpretive considerations presented for the WISC-R Picture Completion subtest generally apply to the WAIS-R (see Chapter 7). However, whereas on the WISC-R three different guiding statements may be given by the examiner when the examinee gives an incorrect response, on the WAIS-R only one type of guiding statement is permitted (asking for the most important part missing when an unessential missing part is given).

Picture Arrangement

The Picture Arrangement subtest requires the examinee to place a series of pictures in a logical sequence. The 10 series are similar to short comic strips. The individual pictures are placed in a specified disarranged order, and the examinee is asked to rearrange the pictures in the "right" order to tell a story. One set of cards is presented at a time. There is little motor action required, as the pictures must simply be shifted to make a meaningful story.

All examinees start with item 1. The first item has two trials and is scored 2, 1, or 0. For the remaining items (2 to 10), 2 points are given for each correct arrangement completed within the time limit. On items 2, 5, 8, and 9, 1 point is given for an acceptable variation of the correct arrangement. Items 1 to 4 have a 60-second time limit; items 5 to 8, a 90-second time limit; and items 9 and 10, a 120-second time limit.

Rationale. The rationale presented for the WISC-R Picture Arrangement subtest applies to the WAIS-R Picture Arrangement subtest (see Chapter 7).

Factor analytic findings. The Picture Arrangement subtest is a fair measure of *g* (45 percent of its variance may be attributed to *g*). The subtest has ample specificity at ages 16 to 19, 25 to 64, and 70 to 74 to warrant specific interpretation of its functions at these ages. It has inadequate specificity at ages 20 to 24 and 65 to 69. Picture Arrangement has modest loadings on the Verbal Comprehension (*Mdn* loading = .40), Perceptual Organization (*Mdn* loading = .33), and Freedom from Distractibility (*Mdn* loading = .22) factors. Picture Arrangement cannot be uniquely allocated to any one of the three factors, however.

Reliability and correlational highlights. Picture Arrangement is relatively reliable (r_{xx} = .74). It correlates more highly with Picture Completion (r = .51) and Vocabulary (r = .51) than with the other subtests. It correlates moderately with the Full Scale IQ (r = .61) and to a lesser degree with the Performance Scale IQ (r = .56) and the Verbal Scale IQ (r = .57).

Administrative and interpretive considerations. The administrative and interpretive considerations presented for the WISC-R Picture Arrangement subtest generally apply to the WAIS-R (see Chapter 7). However, the bonus points awarded on the WISC-R subtest for speed are not awarded on the WAIS-R subtest.

Block Design

The Block Design subtest contains nine items. The examinee is shown two-dimensional, red-and-white pictures of abstract designs and then must assemble a design that is identical to each picture, using three-dimensional red and white plastic blocks. All examinees start with item 1. On this item only, the examinee is required to reproduce a design from a model constructed by the examiner.

The patterns are arranged in order of increasing difficulty. Four blocks are used for the first five designs, and nine for the last four designs.

All items are timed. The first five items have a time limit of 60 seconds; the last four items have a time limit of 120 seconds. On items 1 and 2, the examinee is given 2 points for successful completion on the first trial or 1 point for successful completion on the second trial. On items 3 to 9, 4 points are given for a correct completion, with up to 3 (items 3 and 4) or 4 (items 5 through 9) additional time-bonus points awarded for quick execution. The subtest is discontinued after three consecutive failures.

Rationale. The rationale presented for the WISC-R Block Design subtest applies to the WAIS-R Block Design subtest (see Chapter 7).

Factor analytic findings. The Block Design subtest is the best measure of *g* among the Performance Scale subtests (53 percent of its variance may be attributed to *g*). The subtest has either ample or adequate specificity across the entire age range to permit specific interpretation of its functions. The Block Design subtest contributes substantially to the Perceptual Organization factor (*Mdn* loading = .74).

Reliability and correlational highlights. Block Design is a reliable subtest (r_{xx} = .87). It correlates more highly with Object Assembly (r = .63) than with any other subtest. It correlates moderately with the Full Scale IQ (r = .68), the Performance Scale IQ (r = .70), and the Verbal Scale IQ (r = .61).

Administrative and interpretive considerations. The administrative and interpretive considerations described for the WISC-R Block Design subtest generally apply to the WAIS-R (see Chapter 7). Timing and bonus points differ on the two subtests.

Object Assembly

In the Object Assembly subtest, the examinee must put jigsaw pieces together to form common objects: a manikin (6 pieces), a profile of a face (7 pieces), a hand (7 pieces), and an elephant (6 pieces). The items are presented one at a time, with the pieces presented in a specified disarranged pattern. Examinees are administered all four items.

All items are timed. The time limit is 120 seconds for the first two items and 180 seconds for the last two items. Up to 3 time-bonus points may be awarded on each item for quick execution. The manikin has a maximum [illegible] the face, 12; the hand, 10; and the elephant, 11. Points are also awarded for partially correct performances.

Rationale. The rationale presented for the WISC-R Object Assembly subtest applies to the WAIS-R Object Assembly subtest (see Chapter 7).

Factor analytic findings. The Object Assembly subtest is a fair measure of *g* (40 percent of its variance may be attributed to *g*). The subtest has ample specificity to permit specific interpretation of its functions only at ages 18 to 19. At all other ages, subtest specificity is inadequate. The Object Assembly subtest has a high loading on the Perceptual Organization factor (*Mdn* loading = .71), which makes it interpretable as a measure of perceptual organization.

Reliability and correlational highlights. Object Assembly is the least reliable of the WAIS-R subtests (r_{xx} = .68). It correlates more highly with the Block Design subtest (r = .63) than with any of the other subtests. Its correlation is relatively low with the Full Scale IQ (r = .57), moderate with the Performance Scale IQ (r = .62), and low with the Verbal Scale IQ (r = .49).

Administrative and interpretive considerations. The administrative and interpretive considerations described for the WISC-R Object Assembly subtest generally apply to the WAIS-R.

Digit Symbol

The Digit Symbol subtest is similar to Coding B on the WISC-R. The subtest requires the copying of symbols that are paired with numbers. The sample (or key) consists of nine boxes, each of which contains one of the numbers 1 through 9 and a symbol. Each test box contains a number in the upper portion and an empty space in the lower portion. In the empty space, the examinee must draw the symbol that was paired with the number in the key. There are seven practice boxes, followed by 93 boxes in the subtest proper.

Both examiner and examinee should use pencils without erasers. It is important that the examinee have a smooth drawing surface. One point is allotted for each correct item. The time limit is 90 seconds; no time-bonus points are awarded.

Rationale. The rationale for the WISC-R Coding subtest applies to the WAIS-R Digit Symbol subtest (see Chapter 7).

Factor analytic findings. The Digit Symbol subtest is a fair measure of *g* (36 percent of its variance may be attributed to *g*). It has either ample or adequate specificity across the entire age range to permit specific interpretation of its functions. Digit Symbol has modest loadings on the Verbal Comprehension (*Mdn* loading = .38), Perceptual Organization (*Mdn* loading = .41), and Freedom from Distractibility (*Mdn* loading = .26) factors. Digit Symbol cannot be uniquely allocated to any one of the three factors, however.

Reliability and correlational highlights. Digit Symbol is a reliable subtest (r_{xx} = .82). It correlates more highly with Block Design (r = .47) and Vocabulary (r = .47) than with any other subtests. It has a relatively low correlation with the Full Scale IQ (r = .57), the Performance Scale IQ (r = .52), and the Verbal Scale IQ (r = .54).

Administrative and interpretive considerations. The administrative and interpretive considerations for the WISC-R Coding B subtest generally apply to the WAIS-R Digit Symbol subtest (see Chapter 7).

INTERPRETING THE WAIS-R

Almost all of the material in Chapter 8 on interpreting the WISC-R pertains to the WAIS-R. For example, the successive level approach to test interpretation, profile analysis, Verbal-Performance Scale comparisons, factor score comparisons, and subtest comparisons are essentially the same for both tests. The estimated percentile ranks for subtest scaled scores are shown in Table C-41 in Appendix C. This table also shows suggested qualitative descriptions associated with scaled scores. Table BC-2 on the inside back cover shows the classifications associated with WAIS-R IQs. In Appendix C, Table C-13 summarizes the functions associated with each subtest (substituting Digit Symbol for Coding), Table C-42 presents information about the three scales and factor scores, and Table C-43 gives suggested remediation activities for combinations of Wechsler subtests.

Profile Analysis

As noted above, approaches to profile analysis on the WAIS-R are basically the same as those on the WISC-R (see Chapter 8). The only difference is that different tables in Appendix C must be used.

1. *Comparing Verbal and Performance Scale IQs.* Table C-26 in Appendix C provides the critical values for

paring the Verbal and Performance IQs: 12 at the .05 level and 16 at the .01 level at ages 16 to 17, and 10 at the .05 level and 13 at the .01 level for the average of the nine age groups. Verbal-Performance IQ differences are essentially similar in male and female groups in the standardization sample (Matarazzo, Bornstein, McDermott, & Noonan, 1986). This finding means that similar interpretations can be given to the Verbal-Performance profiles of both males and females. Probabilities associated with various Verbal-Performance Scale differences are shown in Table C-32 of Appendix C.

2. *Comparing each Verbal subtest age-corrected scaled score with the mean Verbal age-corrected scaled score.* Table C-27 in Appendix C provides the critical values for comparing Verbal subtests with the mean of the Verbal subtests (all age-corrected scores). They range from 1.8 to 3.0 at the .05 level and from 2.1 to 3.5 at the .01 level for the six Verbal subtests.

3. *Comparing each Performance subtest age-corrected scaled score with the mean Performance age-corrected scaled score.* Table C-27 in Appendix C provides the critical values for comparing Performance subtests with the mean of the Performance subtests (all age-corrected scores). They range from 2.5 to 3.0 at the .05 level and from 3.0 to 4.2 at the .01 level for the five Performance subtests.

4. *Comparing each subtest scaled score with the mean of the 11 age-corrected subtest scaled scores.* Table C-27 in Appendix C provides the critical values for comparing subtests with the mean of all the subtests (all age-corrected scores). They range from 1.9 to 3.5 at the .05 level and from 2.2 to 4.8 at the .01 level for the 11 subtests.

5. *Comparing sets of individual age-corrected subtest scaled scores.* Table C-26 in Appendix C provides the critical values for comparing sets of subtest scores (all age-corrected scores). They range between 2 and 5 at the .05 level and between 3 and 6 at the .01 level. The values in Table C-26 in Appendix C for subtest comparisons are overly liberal (that is, they lead to too many significant differences) when more than one comparison is made. They are most accurate when a priori planned comparisons are made, such as Comprehension versus Picture Arrangement or Digit Span versus Arithmetic. (See Chapter 8 for additional information that can guide interpretations of subtest comparisons.)

Silverstein (1982c) advises that when you make multiple subtest comparisons you first determine the difference between the highest and lowest age-corrected subtest scores. If this difference is 6 or more age-corrected points, it is significant at least at the .05 level. Differences of 6 or more points between subtests can then be interpreted. If the difference between the highest and lowest subtest score is less than 6 points, multiple comparisons between individual subtests should not be made.

Other Approaches to Profile Analysis

The supplementary approaches to WAIS-R profile analysis described in this section are similar to those discussed for the WISC-R (see Chapter 8).

Base rate differences between each subtest score and an average subtest score in the WAIS-R standardization sample. Table C-31 in Appendix C allows you to see how frequently a particular difference between a subtest score and an average WAIS-R Verbal, Performance, or overall score occurred in the standardization sample. Differences of approximately 3 to 4 points between each subtest score and the respective average Verbal or Performance Scale score were obtained by 5 percent of the standardization sample. *This table should be used only to evaluate differences that have first been found to be reliable.* (See numbers 2, 3, and 4 in the preceding section on profile analysis.)

Base rate Verbal-Performance differences (or probability-of-occurrence approach). Table C-33 in Appendix C presents the empirically observed percentage of individuals in the standardization sample who obtained a given discrepancy between Verbal and Performance Scales. The percentages are shown for five IQ groups and for the total group. For example, 37.8 percent of the individuals in the standardization sample had a 10-point difference between the two IQs.

Comparisons of factor scores. To compare factor scores, you must first convert them to Deviation IQs (see Table C-28 in Appendix C for the conversion table). Table C-26 in Appendix C provides the differences required for significance at the .05 and .01 levels between the three factors (Verbal Comprehension, Perceptual Organization, and Freedom from Distractibility) for ages 16 to 17 and for the average of the nine age groups. Finally, Table C-29 in Appendix C provides the difference scores needed to determine whether any of the individual age-corrected subtest scaled scores that comprise the three factors are significantly different (at the .05 and .01 levels) from the average of all the age-corrected scores that comprise each factor for ages 16 to 17 and for the average of the nine age groups.

As in the WISC-R, factor scores should be compared with other factor scores and not with the Verbal and Performance Scale IQs, to guard against the use of overlapping subtests.

Use of Norm Tables

The norm tables allow each examinee to be compared with his or her age group. The transition point between two normative age groups may affect scores, however, and lead to interpretive problems in some test-retest situations. For example, whereas an examinee aged 19 years, 11 months, 29 days who earns a WAIS-R scaled score total of 100 points receives a Full Scale IQ of 99, the same examinee at 20 years, 0 months receives a Full Scale IQ of 92 for the identical scaled score total. If the same examinee is tested at 19 and 20 years of age, an examiner might be inclined to interpret the drop of 7 points as suggesting a lowering in functioning, when in fact the change is an artifact of the test norms. Such considerations are important to keep in mind when one is evaluating practice effects or conducting psychoeducational reevaluations.

ASSETS OF THE WAIS-R

The WAIS-R is a well-standardized test, with good reliability and validity. It divides the 11 subtests into two sections and provides three IQs—Verbal, Performance, and Full Scale. This procedure is helpful in clinical and psychoeducational work and in the assessment of brain-behavior relationships. The fact that all examinees take a comparable battery of subtests is a valuable feature of the test. Parts of the test also can be administered to examinees limited by sensory impairments (for example, the Verbal Scale to blind individuals or those with motor handicaps; the Performance Scale to deaf individuals).

1. *Good validity.* Concurrent validity data are uniformly positive. WAIS-R IQs correlate significantly with scores from other intelligence tests, measures of academic achievement, and years of formal education. Factor analytic studies indicate that the Full Scale IQ is an excellent measure of *g*, and in most situations the division of the subtests into Verbal and Performance sections is appropriate. Inspection of the age norms for the test indicates that if the Performance Scale subtests are considered as measures of fluid intelligence and the Verbal Scale subtests as measures of crystallized intelligence, then the WAIS-R norms are consistent with predictions based on the Cattell-Horn theory of intelligence.

2. *High reliabilities.* The WAIS-R Full Scale IQ has excellent reliability (average $r_{xx} = .97$). The SE_m's of the IQs on the three scales are consistently less than 5 points. The WAIS-R manual provides reliability data, SE_m's, and intercorrelations of subtest scores for the nine age groups as well as for the average of the nine age groups, permitting evaluation of the test's properties throughout the entire age range covered by the scale. Confidence intervals can be established for IQs for each of the nine age groups (as well as for the average of the nine groups); thus estimates can be made that are applicable to the examinee's specific chronological age group.

3. *Excellent standardization.* The standardization procedures were excellent, sampling four geographic regions, both sexes, white and nonwhite populations, urban and rural residents, and the entire range of socioeconomic classes.

4. *Good administration procedures.* The prescribed procedures for administering the WAIS-R are excellent. Examiners actively probe responses in order to evaluate the breadth of the examinee's knowledge and determine whether the examinee really knows the answer. On items that require two reasons for maximum credit, the examinee is asked for another reason when only one reason is given. These procedures prevent examinees from being penalized for not fully understanding the demands of the question. The emphasis on probing questions and queries is extremely desirable.

5. *Good manual.* The WAIS-R manual is easy to use; it provides clear directions and tables. The examiner's instructions are printed in a different color to facilitate reading of the directions. Helpful suggestions are provided about abbreviations to use in recording responses, such as "Q" for question, "DK" for don't know, "Inc" for incomplete, and "NR" for no response. The test materials are interesting to adolescents and adults.

6. *Helpful scoring criteria.* The criteria for scoring replies have been carefully prepared. The Vocabulary, Comprehension, and Similarities scoring guidelines, for example, give the rationale for the use of 2, 1, and 0 scores and are accompanied by a number of examples that demonstrate the application of the scoring principles. Many typical responses are scored, and those deemed to need further inquiry are indicated by a "(Q)." Studying the scoring sections will aid you not only in scoring responses but also in administering the test.

LIMITATIONS OF THE WAIS-R

Although the WAIS-R is an excellent instrument, some problems exist with the test and the manual.

1. *Limited floor and ceiling.* The range of Full Scale IQs (45 to 150) is insufficient both for moderately to severely retarded persons and for extremely gifted persons. The test is designed so that examinees receive 1 scaled score point on each subtest, even if they give no correct answers. Thus the WAIS-R may not be an appropriate measure for the examinee who earns 0 or 1 raw score point on most subtests.

2. *Nonuniformity of subtest scores.* The range of scaled scores on all subtests is not uniform. At the reference age group (ages 20 to 34) used to obtain scaled scores to calculate IQs, a scaled score of 19 can be earned on only five subtests: Digit Span, Vocabulary, Comprehension, Block Design, and Digit Symbol. The maximum scaled score is 18 on Information, Similarities, and Object Assembly, and 17 on Arithmetic, Picture Completion, and Picture Arrangement. For purposes of profile analysis, the scaled score range is more uniform at ages 16 to 17. At this age group, a scaled score range of 19 can be obtained on nine of the 11 subtests. On the two remaining subtests—Picture Completion and Picture Arrangement—18 is the maximum scaled score.

Nonuniformity is also a problem with the age-corrected subtest scores. The restriction of scores occurs for each of the nine age groups. For example, at ages 45 to 54, scores of 19 can be earned on only six subtests: Digit Span, Vocabulary, Comprehension, Block Design, Object Assembly, and Digit Symbol. At ages 65 to 69, scores of 1 can be obtained on only six subtests: Information, Digit Span, Vocabulary, Comprehension, Object Assembly, and Digit Symbol. The lack of uniformity of available scaled scores and age-corrected scores makes profile analysis more difficult to apply, particularly to the profiles of retarded and gifted examinees. It may be misleading to apply profile techniques uniformly to all subtests for every examinee, because the same number of scaled score points, or age-corrected score points, cannot be obtained on all subtests.

3. *Difficulty of scoring responses.* When responses on the Vocabulary, Comprehension, and Similarities subtests differ from those that appear in the WAIS-R manual, they may be difficult to score. Such difficulties may lead to halo effects in scoring and may contribute to other types of examiner bias. Although mastering the scoring criteria is important for all subtests, it is particularly crucial for these three. Close attention must also be given to the mechanics of scoring.

4. *Lack of normative data for raw scores.* The WAIS-R manual fails to give means, standard deviations, and frequency distributions for the raw scores.

5. *Failure to describe the procedure for establishing discontinuance criteria.* The WAIS-R manual states that discontinuance criteria were established using data from the standardization sample. The procedure is not described further, however.

TEST YOUR SKILL

The WISC-R Test-Your-Skill Exercises in Chapter 8 also apply to the WAIS-R. You are encouraged to review these exercises.

SUMMARY

1. The revised edition of the Wechsler Adult Intelligence Scale, the WAIS-R, is similar to its 1955 predecessor, with 80 percent of the original items retained. The WAIS-R is applicable to individuals from ages 16-0 to 74-11. Standardization of the scale was excellent, including both white and nonwhite individuals.

2. Reliabilities for the IQs associated with the Verbal, Performance, and Full Scales are extremely high for the standardization sample (average r_{xx} of .97, .93, and .97, respectively), with SE_m's for the Full Scale of about 2.5 IQ points.

3. Practice effects (after a two- to seven-week test-retest interval) for standardization subjects were about 3.3 points on the Verbal Scale, 8.4 points on the Performance Scale, and 6.2 points on the Full Scale.

4. Concurrent and construct validity studies of the WAIS-R have been uniformly positive. The scale correlates significantly with education and with other ability measures. Moreover, the distribution of the age norms is consistent with theory-based expectations, and factor analysis indicates that all 11 subtests measure *g* with a moderate to high degree of success.

5. The WAIS-R tends to provide lower IQs than the WAIS and slightly higher IQs than the WISC-R and Stanford-Binet: Fourth Edition, especially for low-functioning individuals.

6. Higher intercorrelations are observed among the Verbal subtests than among the Performance subtests within their respective scales. Vocabulary and Block Design show the highest correlations with the Full Scale IQ (.82 and .67, respectively, at ages 16 to 17).

7. A study of WAIS-R IQs in relation to various stratification variables showed that mean differences between males and females were less than 3 points; the IQs of white subjects were higher than those of black subjects by about 15 points (101.4 vs. 86.8); the mean Full Scale IQ of persons in the highest occupational group was 22 points higher, on average, than that of persons in the lowest occupational group (111.0 vs. 89.0); urban-rural differences and geographic region differences were small, and Full Scale IQs of persons with 16 or more years of education

were, on average, 33 points higher than those of persons with less than 8 years of education.

8. Factor analyses of the WAIS-R usually yield three factors – Verbal Comprehension, Perceptual Organization, and Freedom from Distractibility – but some also report two-factor solutions.

9. The subtests that provide the best measure of *g* are Vocabulary, Information, Similarities, Comprehension, Arithmetic, and Block Design. The remaining subtests are fair measures of *g*.

10. Only some of the subtests have ample subtest specificity at ages 16 to 17 and at other ages throughout the scale. At ages 16 to 17, seven of the subtests have ample or adequate subtest specificity (Information, Digit Span, Vocabulary, Picture Completion, Picture Arrangement, Block Design, Digit Symbol), and four (Arithmetic, Comprehension, Similarities, Object Assembly) have inadequate subtest specificity.

11. Somewhat purer factor scores can be obtained by use of Table C-28 in Appendix C, which converts age-corrected scores into Deviation Quotients as follows: (a) Information, Vocabulary, Comprehension, and Similarities into a Verbal Comprehension Deviation Quotient; (b) Block Design, Object Assembly, and Picture Completion (at every age level except 18 to 19, where the latter subtest should be omitted) into a Perceptual Organization Deviation Quotient; and (c) Digit Span and Arithmetic into a Freedom from Distractibility Deviation Quotient.

12. Although the administrative procedures for the WAIS-R are generally similar to those for the WISC-R, there are some differences. Be sure to use the appropriate procedures for each scale.

13. Table C-30 in Appendix C presents extrapolated IQs for scaled scores that are above those shown in the WAIS-R manual.

14. Numerous WAIS-R short forms have been developed. Tables C-34 through C-40 in Appendix C provide information to assist you in the selection and use of WAIS-R short forms.

15. The rationale and administrative and interpretive considerations for each WAIS-R subtest are similar to those for the respective WISC-R subtests. Consult Chapter 7 for a discussion of these issues.

16. Information is a good measure of *g* and contributes to the Verbal Comprehension factor. Subtest specificity is adequate except at ages 45 to 54. Information is a reliable subtest and correlates highly with Vocabulary.

17. Digit Span is a fair measure of *g*, and contributes to the Freedom from Distractibility factor. Subtest specificity is ample at all ages. Digit Span is a reliable subtest and correlates highly with Arithmetic.

18. Vocabulary is the best measure of *g* in the scale and contributes to the Verbal Comprehension factor. Subtest specificity is adequate at all ages. Vocabulary is the most reliable subtest in the scale and correlates highly with Information.

19. Arithmetic is a good measure of *g* and contributes to the Freedom from Distractibility factor. It has ample or adequate subtest specificity except at ages 16 to 17. Arithmetic is a reliable subtest and correlates best with Vocabulary and Information.

20. Comprehension is a good measure of *g*, and contributes to the Verbal Comprehension factor. Subtest specificity is ample or adequate except at ages 16 to 24 and 55 to 64. Comprehension is a reliable subtest and correlates highly with Vocabulary, Information, and Similarities.

21. Similarities is a good measure of *g* and contributes to the Verbal Comprehension factor. Subtest specificity is ample or adequate except at ages 16 to 17 and 20 to 24. Similarities is a reliable subtest and correlates best with Vocabulary and Comprehension.

22. Picture Completion is a fair measure of *g* and contributes to the Perceptual Organization factor at all ages except 18 to 19. Subtest specificity is ample at all ages. Picture Completion is a reliable subtest and correlates highly with Vocabulary.

23. Picture Arrangement is a fair measure of *g*. Subtest specificity is ample except at ages 20 to 24 and 65 to 69. Picture Arrangement is a reasonably reliable subtest and correlates highly with Picture Completion and Vocabulary.

24. Block Design is a good measure of *g* and contributes to the Perceptual Organization factor. Subtest specificity is ample or adequate at all ages. Block Design is a reliable subtest and correlates highly with Object Assembly.

25. Object Assembly is a fair measure of *g* and contributes to the Perceptual Organization factor. Subtest specificity is ample only at ages 18 to 19. Object Assembly is the least reliable subtest in the scale and correlates highly with Block Design.

26. Digit Symbol is a fair measure of *g*. Subtest specificity is either ample or adequate at all ages. Digit Symbol is a reliable subtest and correlates more highly with Block Design and Vocabulary than with the other subtests.

27. The methods described in Chapter 7 for interpreting the WISC-R also pertain, for the most part, to the WAIS-R.

28. The norm tables should be carefully studied in test-retest situations.

29. The assets of the WAIS-R include its good concurrent validity, high reliabilities, excellent standardization, good administration procedures, good manual, and helpful scoring criteria.

30. Limitations of the WAIS-R include limited floor and ceiling, nonuniformity of subtest scores, difficulty of scoring responses, lack of normative data for raw scores, and failure to describe the procedure for establishing discontinuance criteria.

KEY TERMS, CONCEPTS, AND NAMES

Wechsler-Bellevue Intelligence Scale (p. 220)
WAIS-R standardization (p. 220)
WAIS-R Deviation IQ (p. 220)
WAIS-R scaled scores (p. 220)
Prorating procedure (p. 220)
Scaled score equivalents for age groups (p. 220)
Reliability of the WAIS-R (p. 220)
Standard errors of measurement of the WAIS-R (p. 221)
Stability of the WAIS-R (p. 222)

Precision range of WAIS-R IQs (p. 222)
Criterion validity of the WAIS-R (p. 223)
Relationship between the WAIS-R and the WAIS, the WISC-R, and the Stanford-Binet: Fourth Edition (p. 223)
Construct validity of the WAIS-R (p. 224)
Cattell-Horn theory (p. 224)
WAIS-R subtest intercorrelations (p. 225)
WAIS-R IQs and stratification variables (p. 227)
Premorbid estimation of WAIS-R IQ (p. 227)
Factor analysis of the WAIS-R (p. 227)
WAIS-R Verbal Comprehension factor (p. 228)
WAIS-R Perceptual Organization factor (p. 228)
WAIS-R Freedom from Distractibility factor (p. 228)
WAIS-R subtests as measures of *g* (p. 228)
Subtest specificity on the WAIS-R (p. 228)
WAIS-R factor scores (p. 228)
Starting rules on the WAIS-R (p. 231)
Discontinuance rules on the WAIS-R (p. 231)
Extrapolated IQs on the WAIS-R (p. 232)
WAIS-R short forms (p. 234)
Satz-Mogel abbreviated procedure for the WAIS-R (p. 234)
WAIS-R Information (p. 235)
WAIS-R Digit Span (p. 235)
WAIS-R Vocabulary (p. 235)
WAIS-R Arithmetic (p. 236)
WAIS-R Comprehension (p. 236)
WAIS-R Similarities (p. 237)
WAIS-R Picture Completion (p. 237)
WAIS-R Picture Arrangement (p. 237)
WAIS-R Block Design (p. 238)
WAIS-R Object Assembly (p. 238)
WAIS-R Digit Symbol (p. 239)
Profile analysis (p. 239)
Base rate Verbal-Performance differences (probability-of-occurrence approach) (p. 240)

STUDY QUESTIONS

1. Discuss the following topics with respect to the WAIS-R: standardization, Deviation IQs, scaled score equivalents for age groups, reliability, and validity.
2. Describe WAIS-R factor analytic findings.
3. Discuss some important factors involved in administering the WAIS-R.
4. Discuss WAIS-R short forms. Include a discussion of their values and limitations.
5. Discuss the rationale, factor analytic findings, reliability and correlational highlights, and administrative considerations for each of the following WAIS-R subtests: Information, Digit Span, Vocabulary, Arithmetic, Comprehension, Similarities, Picture Completion, Picture Arrangement, Block Design, Object Assembly, and Digit Symbol.
6. Discuss the intent of profile analysis, methods of profile analysis, and approaches to profile analysis on the WAIS-R.
7. Discuss the assets and limitations of the WAIS-R.

WISC or WAIS AGE-SCALE FACTOR INTERPRETATIONS - For Educational and Vocational Guidance

Note: A score of 10 is the norm for a person of this age. The following student rating scale is based on a standard deviation of three.

Age-Scale Score SD=3, $\bar{X}$=10	Student Rating	IQ $\bar{X}$=100, SD=15	%ile Range
16 and up	Very Superior	130+↑	95 - 99
14 and 15	Superior	120-129	85 - 94
12 and 13	High Average	110-119	70 - 84
9,10, and 11	Average	90-109	30 - 69
7 and 8	Low Average	80-89	15 - 29
5 and 6	Boarderline	70-79	5 - 14
4 and below	Mentally Deficient	69+↓	1 - 4

VERBAL SCALE	Age Scale __Score	Student Rating	Mental Process Explanation
Information			Memory for previously acquired everyday knowledge. Reflects alertness of world about person, social and educational background.
Comprehension			Utilization of practical information in everyday problem solving situations. Requires judgement in deciding how to meet a situation.
Similarities			Discrimination in selecting fundamental from superficial in abstract thinking. Shows logical thinking and verbal concept formation.
Vocabulary			Recall of previously acquired word meanings. Shows ability to express verbal ideas at the varying levels of word difficulty. Shows organization as well as expression of ideas. Quality of ideas and mode of expression revealed.
Arithmetic			Mental arithmetic reasoning (ordinary business arithmetic transactions - 7th grade level of difficulty - under stress of time limits.) Requires concentration free from emotional reaction.
Digit Span			Shows attention span, auditory receptivity, concentration, rote memory and immediate recall.

PERFORMANCE SCALE	Age Scale Score	Student Rating	Mental Process Explanation
Picture Arrangement			Ability to comprehend (perceive and conceive) a total social situation in terms of sequence of events. Involves logical planning based on anticipation and social insight.
Picture Completion			Utilizes past experience in the ability to see a picture as a whole and then differentiate between essential and unessential detail in detection of a missing part. This is perceptual and conceptual abilities tested by pictures.
Block Design			Involves ability to perceive and analyze patterns in multiple relationships under time requirements. This is analytic in perception and synthetic in putting the design together with the multiple colored blocks. Trial and error persistency and visual-motor coordination are reflected.
Object Assembly			Initiative in seeking and achieving an unknown goal. Conception and perception of parts of a familiar configuration. Requires ability to organize and re-organize under speed requirements.
Digit Symbol			Speed of working with symbols, associating unfamiliar symbols with familiar numerals. Shows visual-motor coordination and psycho-motor speed. Aptitude for clerical-like tasks.

Implication For Functional Use Of The WAIS With The Severely Mentally Ill (SMI) Clients

MEASURE	TASK	BEHAVIOR REQUIRED	FUNCTIONAL IMPLICATIONS	SMI PERFORMANCE
Information	Answer questions of fact	Wealth of factual data, verbal expressiveness, long term memory	Mental alertness, ability to express ideas verbally, index of premorbid level of functioning	Schizophrenics do less well on items requiring judgment rather than simple recall
Comprehension	Solve verbal problems and interpret proverbs	judgement and logical thinking, abstract thinking, long term memory, ability to express ideas verbally	common sense, judgment, and problem solving, ability to form or understand abstractions, ability to express ideas verbally	schizophrenics do poorly, because of poor judgment—High scores on comprehension with CMI suggest good reality contact, an index of stability for rehabilitation planning
Similarities	Detect similarities between two familiar objects or concepts	Logical thinking, verbal concept formation, ability to generalize between two objects of a common class	Ability to make generalizations from one situation to another, ability to see relationships between things	The complex cognitive skills required are particularly sensitive to deterioration in persons with CMI — High scores in persons with schizophrenia associated with good prognosis
Vocabulary	Provide (orally) definitions of words	Ability to recall word meanings previously learned	Verbal facility, ability to communicate effectively with others, comprehension of verbal material, estimate of premorbid abilities	Vocabulary is the primary "hold" test in that it is very resistant to changes and mental deterioration

Implication For Functional Use Of The WAIS With The Severely Mentally Ill (SMI) Clients (Continued)

MEASURE	TASK	BEHAVIOR REQUIRED	FUNCTIONAL IMPLICATIONS	SMI PERFORMANCE
Arithmetic	Mental calculation of arithmetic word problems	Number concept, attention, concentration, and freedom from distractibility	Ability to attend and concentrate on mental tasks, ability to solve functional arithmetic problems	Highly sensitive to emotional states (anxiety, depression)
Digit Span	Immediate recall of number series, forward and backward	Attention, concentration, learning memory, nonverbal spatial skills (reverse ordering of number series)	The ability to pay attention and concentrate, the ability to hold and manipulate information mentally	Subtest is very sensitie to brain damage and anxiety — major depressives and deteriorated schizophrenics do poorly
Picture Completion	Identifying missing elements in sketches	Visual, acuity, visual perception, visual scanning, attention	The ability to discriminate what is important from what is nonessential and screen out what is not important, the ability to concentrate on and make sense of a visual image	Decreased performance is noted in persons with deteriorated schizophrenia — Persons with paranoid schizophrenia insist there are no missing parts

Implication For Functional Use Of The WAIS With The Severely Mentally Ill (SMI) Clients (Continued)

MEASURE	TASK	BEHAVIOR REQUIRED	FUNCTIONAL IMPLICATIONS	SMI PERFORMANCE
Picture Arrangement	Arrange sets of cartoon pictures to tell logical stories	Visual acuity and perception, sequential logic and planning, cognitive flexibility	The ability to size up social situations in terms of sequences of events (social awareness and insight), planning skills, organizing skills, the ability to form hypotheses and test them	Many provide qualitative information about social judgment problems in persons with SMI
Block Design	Arrange six-sided, colored, blocks to match designs presented on cards	Attention, concentration, motor coordination, visual analysis, spatial reasoning, visual construction	The ability to pay attention to and persist in a trial-and-error fashion on a nonverbal problem solving task, the ability to comprehend and perform nonverbal, spatial problems as required in such occupations as engineering or drafting — severe deficits may be associated with directional or time problems	Test is very sensitive to brain damage — Persons with schizophrenia tend to do well, making it a good discriminator between functional schizophrenia and structural brain disease

1572

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Implication For Functional Use Of The WAIS With The Severely Mentally Ill (SMI) Clients (Continued)

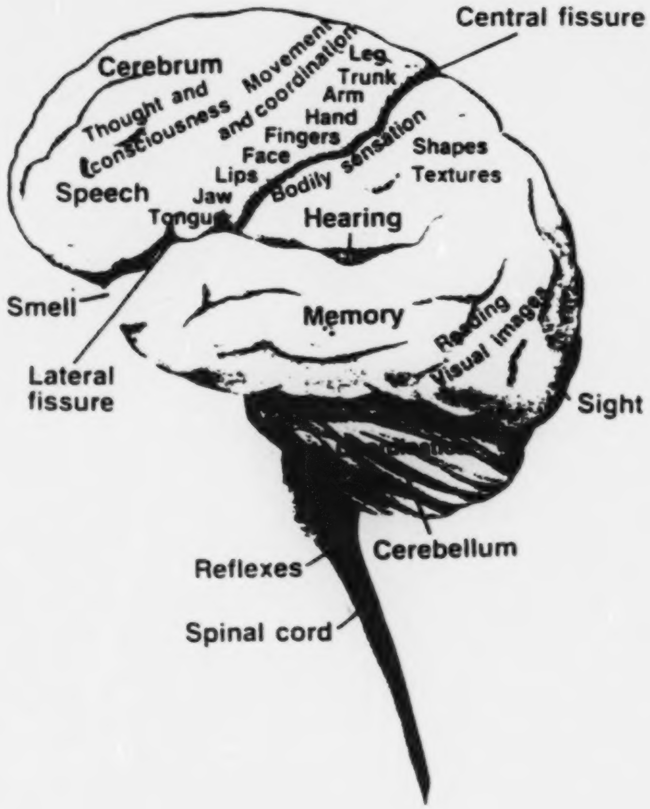
MEASURE	TASK	BEHAVIOR REQUIRED	FUNCTIONAL IMPLICATIONS	SMI PERFORMANCE
Object Assembly	Solve jigsaw-type puzzles requiring assembly of familiar forms	Visual perception and construction, motor coordination, cognitive flexibility	The ability to make sense of visual patterns and translate visual concepts into motor action, persistence, solving a problem from part-to-whole	Persons with schizophrenia do poorly because of speed requirements – the effects of neuroleptic medication may have a negative effect
Digit Symbol	Record symbols matched with numbers using a code	Visual perception, eye-hand speed and coordination, memory, attention	Ability to learn new material, pay attention, persistence and diligence, visual-motor quickness	Very sensitive to anxiety and psychomotor retardation – Also sensitive to even mild forms of brain disease

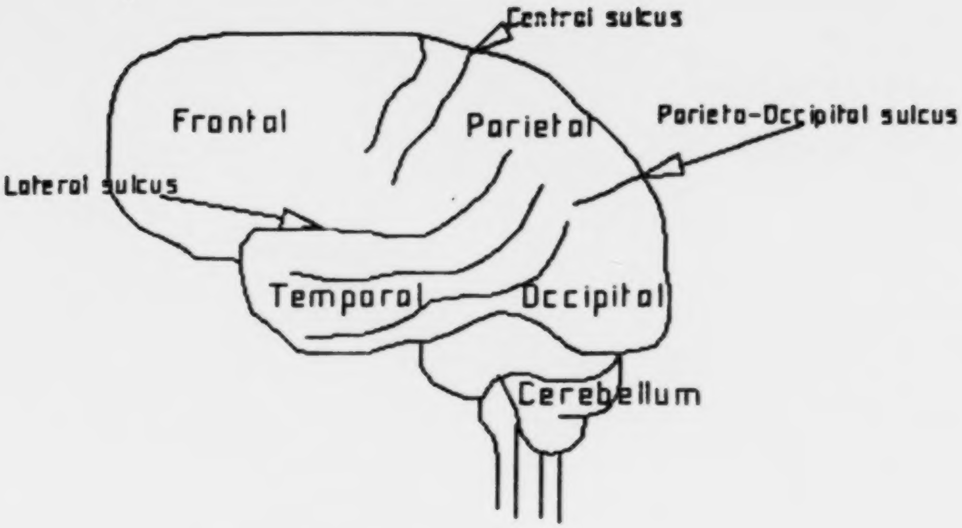
BANNATYNE RECATEGORIZED SCORES, WISC-R
WAIS-R

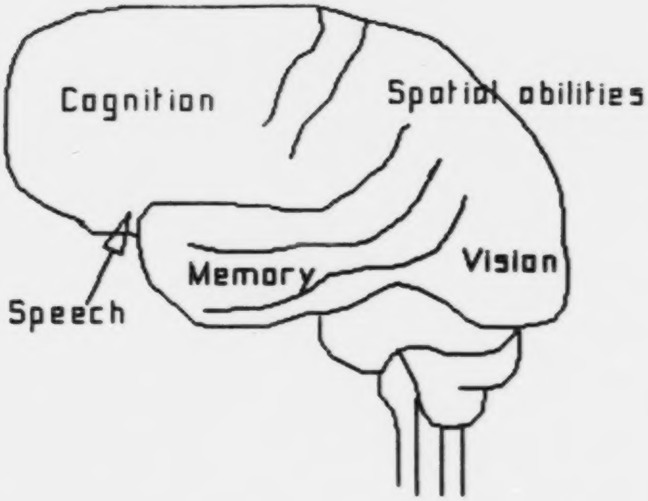
SPATIAL	CONCEPTUAL	SEQUENTIAL	ACQUIRED KNOWLEDGE
Block	Vocab.	Digit Span	Info.
Obj. Assembly	Similarities	Digit Symbol	Arith.
Picture Compln.	Comprehension	Arithmetic	Vocab.

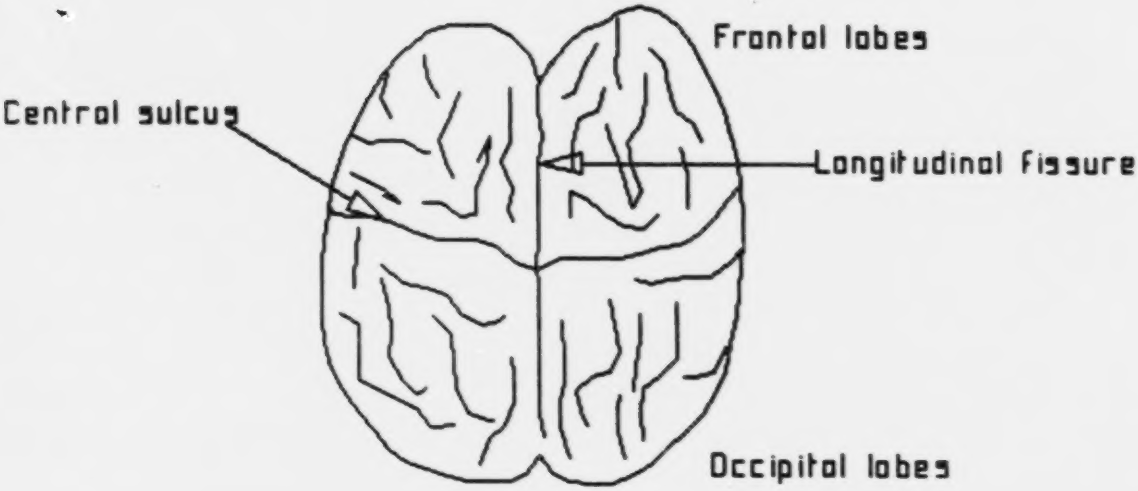
The brain's activity centers

Certain areas in the brain help to control and direct many functions of a person's body


Central fissure
Cerebrum
Thought and consciousness
Movement and coordination
Leg
Trunk
Arm
Hand
Fingers
Face
Lips
Jaw
Tongue
Bodily sensation
Shapes
Textures
Speech
Hearing
Smell
Memory
Reading
Visual images
Lateral fissure
Sight
Cerebellum
Reflexes
Spinal cord


Central sulcus
Frontal
Parietal
Parieto-Occipital sulcus
Lateral sulcus
Temporal
Occipital
Cerebellum


Cognition
Spatial abilities
Speech
Memory
Vision


Frontal lobes
Central sulcus
Longitudinal fissure
Occipital lobes

IMPAIRMENTS ASSOCIATED WITH LOBES LESIONS

Anterior ◁—— Posterior

FRONTAL	PARIETAL
Movements organization and monitoring Motor Aphasia (Broca) lack of thought expression no spontaneous statement Visual tracking Abstract thinking controversy problem of definition problem of measurment Frontal amnesia no planning of remembering no use of knowledge Regulation disorders state of activation emotional life control of inhibition Personality frontal lobe syndrome Phineas P.Gage case Perseveration error evaluation	Somatosensory discrimination Tactile Perception Intersensory association Spatial Orientation location Memory (topography) Constructional apraxia Spatial Aphasia Dyslexia Dyscalculia Unilateral Spatial Neglect Aperception of illness (Anosagnosia) of Body parts Prosopagnosia (faces)
TEMPORAL	**OCCIPITAL**
Audition sensation Association(receptive aphasia) Perceptual integration Audition Vision Olfaction Hallucinations (Penfield) Memory (verbal, N-verbal) Karsakoff Syndrome	Visual perception Hemianopias Visual agnosia Prosopagnosia (faces) Color Agnosia

N.B. This description is not exhaustive and is arbitrary

REPORT WRITER'S HELPER

Macros and Text Blocks

MACROs

Word Perfect macros are special files containing commands in the Word Perfect language (text may be embedded within the string of commands). Each macro's function is to reduce a set of many keystrokes to a small number of keystrokes. This is especially useful in cases where a particular task is performed repeatedly. All Word Perfect macro files have the filename extension "WPM". The file name is also the name of the macro with the exception of the <ALT> key macros which are named ALT<letter>.WPM. In the PRAS clinic, all true Word Perfect macros are stored in a separate directory: C:\WP51\WPM.

TEXT BLOCKS

Word perfect allows the inclusion of other documents into the document that is being worked on. This is simply a matter of retrieving the appropriate file (<SHIFT><F10>). Over the course of many years, Dr. Katz and her staff have created a considerable number of small (sometimes larger) pieces of text that have been used over and over in reports and other documents. [Such blocks of text are often called boilerplate.] These came to be known as "macros" although they are not true Word Perfect macros (see above), but simply files of formatted text. In PRAS these files have been collected into a special directory (C:\WP51\TEXTBLK) and compiled into a printout alphabetized by file name. A macro has been created to facilitate the retrieval of these text blocks. The following procedure is used:

Place the cursor at the point you want the text to appear
<ALT> A
enter the full name of the text block
<ENTER>

Because these text blocks were created over many years and on many systems, the formatting may not work very well for you. I have tried to make the more recently used text blocks completely portable (assuming a base font size of 12 point or smaller); any text block file dated later than mid-1993 should act reasonably. Older files may produce rather peculiar results. Check it out in Reveal Codes. Where a text block contains a tabular format I have set explicit tabs at the beginning of the table and reset the tabs to the default at the end.

TESTS.NUM

1. Wechsler Adult Intelligence Scale - Revised (WAIS-R)
2. Wide Range Achievement Test - Revised (WRAT-R)
3. Wechsler Memory Scale - Revised (WMS-R)
4. Gates MacGinitie Reading Comprehension Test
5. Career Ability Placement Survey (CAPS)
6. Career Orientation Placement and Evaluation Survey (COPES)
7. Career Occupational Preference System Interest Inventory (COPS)
8. Minnesota Multiphasic Personality Inventory (MMPI)
9. Millon Clinical Multiaxial Inventory (MCMI)
10. Luria-Nebraska Neuropsychological Battery (LNNB)
11. Halstead-Reitan Neuropsychological Battery (HRNB)
12. Rey Complex Figure
13. Hooper Visual Organization Test
14. Purdue Pegboard
15. Finger Tapping
16. Hand Dynamometer
17. Smith Symbol Digit Modalities Test
18. Star Drawing Test
19. Benton Visual Discrimination Test
20. Benton Judgment of Line Orientation Test
21. Boston Diagnostic Aphasia Examination (BDAE)
22. Wisconsin Card Sorting Test
23. Trails A and B
24. Vocational Interest Profile Report (VIP)
25. Auditory Analysis Test
26. Woodcock Reading Mastery Tests
27. SCL-90-R
28. Coopersmith Self Esteem Inventory (SEI)
29. Rotter Incomplete Sentences
30. Jordan Left-Right Reversal Test
31. Wide Range Interest Opinion Test (WRIOT)
32. Multidimensional Self-Esteem Inventory (MSEI)
33. Developmental Test of Visual Motor Integration
34. Strong Campbell Interest Inventory
35. Raven Standard Progressive Matrices
36. Boston Naming Test
37. Blessed Dementia Rating Scale
38. Detroit Tests of Learning Aptitude
39. Short Category Test
40. California Verbal Learning Test (CVLT)
41. Receptive One-Word Picture Vocabulary Test
42. Expressive One-Word Picture Vocabulary Test
43. Seashore Rhythm Test
44. Speech-Sounds Perception Test
45. Token Test
46. Key Math Diagnostic Arithmetic Test
47. Thematic Apperception Test (TAT)
48. Peabody Picture Vocabulary Test Revised (PPVT-R)
49. Booklet Category Test (BCT)
50. Career Occupational Preference System Interest Inventory, Professional Level COPS-P).
51. Rorschach

52. Porteus Maze Test
53. Money Map
54. Greek Cross
55. Mattis Dementia Rating Scale
56. Children's Apperception Test
57. Stroop Color-Word Test
58. Test of Written Language
59. Luria-Nebraska Neuropsychological Battery Abbreviated Version (LNNB-S)
60. Peabody Individual Achievement Test
61. Tactual Performance Test
62. Frostig Developmental Test of Visual Perception
64. Finger Oscillation Test
65. Famous Faces
66. Benton Facial Recognition Test
67. Wechsler Intelligence Scale for Children - Revised (WISC-R)
68. McCarthy Scales of Children's Abilities
69. Clinical Evaluation of Language Fundamentals-Revised
70. Bender Gestalt Visual Motor Test
71. Stanford-Binet Intelligence Scale - Fourth Edition
72. Peabody Picture Vocabulary Test (Form A)
73. Gates MacGinitie Reading Test (Level 10/12 Form K)
74. Gates MacGinitie Reading Test (Level 10/12 Form L)
75. Nelson-Denny Reading Test (Form E)
76. Meyers-Briggs Type Indicator (MBTI)
77. House-Tree-Person Drawings
78. Kinetic Family Drawing
79. Discrepancy Discriminator Index (DDI)
80. Minnesota Multiphasic Personality Inventory (MMPI-168 Items)
81. Minnesota Multiphasic Personality Inventory (MMPI-71 Items)
82. Reynolds Adolescent Depression Scale (RADS)
83. Finger Tip Number Writing Test
84. Woodcock Johnson Test of Achievement - Revised
85. Aphasia Screening Test
86. Test Of Written Language - 2 (TOWL-2)
87. Gray Oral Reading Test - 3 (GORT-3)
88. Wechsler Intelligence Scale for Children III (WISC-III)
89. Wide Range Assessment of Memory and Learning (WRAML)
90. Wechsler Individual Achievement Test (WIAT)
91. Paced Auditory Serial Addition Test (PASAT)
92. Controlled Oral Word Association
93. Sensory Perceptual Examination
94. Animal Naming Test
95. Perceptual Speed Test
96. Beck Depression Inventory (BDI)
97. Boder Test of Reading-Spelling Patterns
98. Millon Clinical Multiaxial Inventory - II (MCMI-II)
99. Minnesota Multiphasic Personality Inventory - II (MMPI-II)
100. Connor's Continuous Performance Test (CCPT)
101. Nelson-Denny Reading Test (Form F)
102. Wide Range Achievement Test - 3 (WRAT-3)
103. Children's Auditory Verbal Learning Test - 2 (CAVLT-2)
104. Children's Category Test

TESTS.ALB

94.	Animal Naming Test
85.	Aphasia Screening Test
25.	Auditory Analysis Test
96.	Beck Depression Inventory (BDI)
70.	Bender Gestalt Visual Motor Test
66.	Benton Facial Recognition Test
20.	Benton Judgment of Line Orientation Test
19.	Benton Visual Discrimination Test
37.	Blessed Dementia Rating Scale
97.	Boder Test of Reading-Spelling Patterns
49.	Booklet Category Test (BCT)
21.	Boston Diagnostic Aphasia Examination (BDAE)
36.	Boston Naming Test
40.	California Verbal Learning Test (CVLT)
5.	Career Ability Placement Survey (CAPS)
50.	Career Occupational Preference System Interest Inventory, Professional Level (COPS-P).
7.	Career Occupational Preference System Interest Inventory (COPS)
6.	Career Orientation Placement and Evaluation Survey (COPES)
56.	Children's Apperception Test
103.	Children's Auditory Verbal Learning Test - 2 (CAVLT-2)
104.	Children's Category Test
69.	Clinical Evaluation of Language Fundamentals-Revised
100.	Connor's Continuous Performance Test (CCPT)
92.	Controlled Oral Word Association
28.	Coopersmith Self Esteem Inventory (SEI)
38.	Detroit Tests of Learning Aptitude
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ABSTRACT.ABL

The Halstead-Reitan also provides us with tests geared toward the evaluation of abilities in abstraction, reasoning, logical analysis, flexibility and planning. In Reitan's view the best measures of those functions are the Category Test, Part B of the Trail Making Test, and the Coding subtest from the Wechsler Scale. These tests generally assess the integration of neuropsychological functions as well as problem-solving skills. The Category Test requires the subject to view a series of designs, discern common elements that form the basis for a consistent application of an organizing principle, and finally, apply the principle to the apparently diverse stimulus configurations. This test heavily emphasizes abstraction, reasoning, and logical analysis. Part B of the Trail Making Test requires the individual to keep the alphabetical and numerical sequences in mind, shifting back and forth while integrating them and simultaneously searching the page for the correct stimulus item, all under the pressure of doing the task as quickly as possible. This test emphasizes flexibility in organizing stimulus material, keeping two sequences in mind at the same time, and accomplishing the task quickly. The Coding subtest achieves its organizational component from the requirement to observe, select, and match stimuli that come from rather different domains.

ACADEMI.TXT

Academic Skills:

Having delineated areas of information processing strengths and deficits, we can now address the specific academic deficiencies displayed. We encounter an individual who has not developed beyond the basic linkages between sound and symbol relationships. Levels of grapheme-phoneme correspondence are adequate for vowels and consonants, but where "blends" or "chains" of sound-symbol relationships are concerned there are significant problems. When asked to write phonemes, gross dysphonetic errors were encountered. Thus, the rudimentary "phonics" skills essential to reading and spelling are very critically underdeveloped in this individual.

We can infer that multiple factors likely coalesce to limit expression of primary academic skill competencies. These include a central auditory information processing deficit manifest primarily in very weak sequential information processing, a fundamental impairment in grapheme-phoneme correspondence, and subtle-residual visuo-perceptual dysfunction secondary to an ocular motor problem.

Considering this individual's age, the severity of this mixed academic disability, and the complexity of the underlying information processing deficits, we would not encourage a significant investment in remedial educational efforts. Compensatory instructional strategies incorporating whole word recognition (i.e., a "look-say approach to reading) or building fundamental primary math skills via the use of a calculator should certainly be considered. Further development of academic skill competencies beyond "survival skill levels" is reviewed as otherwise quite limited. We would instead refocus vocational rehabilitation efforts on opportunities to develop skills and competencies in occupational categories which make minimal demands on literacy skills.

ADHD.BAT

Wechsler Adult Intelligence Scale - Revised (WAIS-R), Wide Range Achievement Test - Revised (WRAT-R), Halstead-Reitan Neuropsychological Battery (HRNB), Rey-Osterrieth Complex Figure Drawing, Hooper Visual Organization Test, Smith Symbol Digit Modalities Test, Star Drawing Test, SCL-90-R, Multidimensional Self-Esteem Inventory (MSEI), California Verbal Learning Test (CVLT), Stroop Color-Word Test, Nelson-Denny Reading Test (Form E), Wechsler Memory Scale - Revised (WMS-R), Paced Auditory Serial Addition Test (PASAT), Beck Depression Inventory (BDI), Millon Clinical Multiaxial Inventory - II (MCMI-II), Minnesota Multiphasic Personality Inventory - II (MMPI-II), Connor's Continuous Performance Test (CCPT).

ARTS.DES

ARTS, Design occupations involve activities concerned with the individualized expression of creative talent in fine arts and design. Sample occupations include Fashion Designs, Landscape Architect, and Art Teacher.

ARTS.PER

ARTS, Performing occupations involve activities concerned with the individualized expression of creative or musical talent. Sample occupations include Musician, Choreographer, Dancer, and Actress.

ARTS.PRO

Professional Arts occupations involve individualized expression of creative or musical talent. They include the fields of design, fine arts and performing arts. Sample occupations include Dance Instructor, Music Teacher, and Display Manager.

ARTS.SKL

Skilled Arts occupations involve application of artistic skill in the fields of photography, graphic arts and design. Sample occupations include Layout Planner (printing), Sign Printer, and Commercial Photography.

BANNA

Bannatyne recategorization of WAIS-R scores looks at three cognitive factors which have been linked with and are utilized in the processing of information and learning and a fourth factor labeled, Acquired Knowledge. The three primary factors consist of spatial, conceptual, and sequential ability areas, each of which is summarized by way of a mean rating. The spatial category is based upon the Block Design, Object Assembly, and Picture Completion subtests; the Conceptual category is based upon the Vocabulary, Similarities, and Comprehension subtests; and the sequential category is comprised of the Digit Span, Digit Symbol, and Arithmetic subtests. The final category, Acquired Knowledge is based upon the Information, Arithmetic, and Vocabulary subtests and thus generally reflects the impact of formal academic experiences. 's Bannatyne recategorized scores result in the following profile:

Spatial	>	Conceptual	>	Sequential	Acquired Knowledge
M =		M =		M =	M =

BODER.TXT

The Boder Test is based on the premise that the dyslexic reader has a characteristic pattern of cognitive strengths and weaknesses in two distinct components of the reading process: the visual gestalt function and the auditory analytic functions. The visual gestalt function underlies the ability to develop a sight vocabulary through visual perception and memory for whole words; the auditory analytic function underlies the ability to develop phonic word-analysis skills. Thus, via the Boder Test one can (1) differentiate specific reading disability from nonspecific reading disability through reading and spelling performance; (2) classify dyslexic readers into one of three subtypes based on their reading-spelling patterns (dysphonetic, dyseidetic, Mixed Dysphonetic-Dyseidetic); and (3) assist in providing guidelines for remediation of the four reading disability subtypes identified by the test (the nonspecific reading disability plus the three dyslexic reading groups).

BODERIII.TXT

Boder's Group III dyslexics show the combined deficits of dysphonetics and dyseidetics. They have weaknesses in both visual gestalt and the auditory analytic functions (which may not be equally severe), with resulting disability in developing both sight vocabulary and phonic skills. The reading errors typical of dyslexics in this category are wild guesses from minimal clues ("fish" for *father*) and visuospatial reversals ("on" for *no*, "pig" for *big*). Their typical spelling errors are phonetically accurate and often bizarre ("r" for *stop*). They are usually the most severely handicapped, educationally, of all dyslexic readers and may not be able to read either at sight or by ear, though they may be either more audile or more visile. Like dyseidetic readers, Group III dyslexics have difficulty learning what the letters sound like. In addition, like Group II readers, they often have persistent visuospatial difficulties. They tend to confuse reversible letters (b-d, p-q, m-w, and n-u), reversible words ("saw" for *was*), and letters with subtle graphic differences (h-n and v-y).

Without intensive remedial reading instruction, severe Group III dyslexics may remain nonreaders, or virtually alexic, even in high school. The words that they recognize at sight or can write correctly are typically on the primer or preprimer level. Characteristically, their response to initial remedial teaching is painfully slow, but their ultimate prognosis for functional reading and spelling can be quite favorable with skillful and appropriate remediation. The spelling pattern of Group III dyslexics is phonetically inaccurate, like that of Group I, but their misspellings are even more unusual--- commonly a sequence of letters unrelated to the dictated word, one wrong initial letter, or a scribble. In the same sense that they are nonreaders, they are nonspellers. Group III readers can be differentiated from Group I by the much lower grade level of their sight vocabulary and from Group II by their lack of phonic skills. They often appear to have a sense of defeat and exhibit a phobic withdrawal from reading and writing tasks.

Although many factors are involved in the prognosis for a dyslexic child, the four diagnostic reading-spelling patterns have been found in long-term observation to have definite prognostic implications that differ for each reader subtype. As might be expected, the prognosis for Groups I and II, in which only one sensory channel function (gestalt or analytic) is deficient, is usually more favorable than the prognosis for Group III, in which both visual and auditory channel functions are impaired, though not necessarily to the same extent. Without intensive long-term remedial teaching, severe Group III dyslexics may remain nonreaders and nonspellers even in high school. With appropriate remediation, however, the prognosis for acquiring functional reading and spelling skills, even for severe Group III dyslexics, has proved to be favorable. According to Boder, a number of highly motivated, intelligent Group III dyslexics have been able to attain fifth- or sixth-grade sight vocabularies in high school. Although the severity of the dyslexic problem in the three subtypes is not determined by overall mental ability, children with above average intelligence are consistently found to be better able to develop compensatory mechanisms in overcoming their reading-spelling disability than children with below average intelligence.

BUSINESS.FIN

BUSINESS, Finance occupations involve activities concerned with the control of monies and accounting for the finances of large businesses and government bureaus. Sample occupations include Accountant, Financial Planner, Economist and Market-Research Analyst.

BUSINESS.MAN

BUSINESS, Management occupations involve activities concerned with the organization, direction and administration of the operation of large businesses and government bureaus. Sample occupations include Benefits Manager, Contracts Manager, Hotel Manager, and College-Business Manager.

BUSINESS.PRO

Professional Business occupations include positions of high responsibility in the organization, administration and efficient functioning of business and governmental bureaus. They involve finance and accounting, management, and business promotion. Sample occupations include Accountant, Management, and Medical Records Administrator.

BUSINESS.SKL

Skilled Business occupations involve sales, promotion and marketing and the correlated financial and organizational activities of business. Sample occupations include Salesperson, Appraiser, Broker, and Wholesaler.

CAPS-ALT.TXT

Scores on the CAPS help to evaluate relative strengths and weaknesses in terms of the eight abilities briefly described below.

MR	Mechanical Reasoning measures understanding of basic mechanical facts and principles and the laws of physics. This ability is important in technical and mechanical fields, skilled trades and industrial arts, as well as many scientific and agricultural pursuits.
SR	Spatial Relations measures the ability to visualize or think in three dimensions and mentally picture the position of objects in space from a two-dimensional diagram of picture. This ability is important in the arts, industrial arts, skilled trades, engineering and many scientific occupations.
VR	Verbal Reasoning measures how well an individual can reason logically with words given facts and possible conclusions which may be drawn from those facts, and facility for understanding and using concepts expressed in words. The ability to reason accurately is important in general academic success, jobs requiring written or oral communication, science, service and business.
NA	Numerical Ability measures basic computational skills, mathematical reasoning, and the ability to use numbers and work with quantitative materials and ideas. This ability is important in many school courses and is required in varying degrees in almost all of the scientific, technical, business and clerical fields.
LU	Language Usage measures how well an individual can recognize and use standard English grammar, punctuation, and capitalization. This ability is important in jobs requiring written or oral communication, clerical jobs, professional level science occupations, and in all levels of business and service.
WK	Word Knowledge measures how well a person can understand the meaning and precise use of words. This is important in communications and all professional level occupations involving high levels of responsibility and decision making.
PSA	Perceptual Speed and Accuracy measures how well an individual can perceive small details rapidly and accurately with a mass of letters, numbers and symbols. This ability is important in office work and other jobs requiring fine visual discrimination.
MSD	Manual Speed and Dexterity measures the ability to make rapid and accurate movements with the hands. This ability is important in Arts-Skilled and Technology-Skilled occupations and other jobs requiring speed and dexterity in the use of the hands.

CAPS.TXT

On the CAPS, a measure of eight primary ability areas associated with the Occupational Clusters presented in the CCOPS vocational aptitude and interest battery, the following aptitude scores were derived:

	Primary Ability	Stanine Score	Percentile Score	Range
MR	Mechanical Reasoning			
SR	Spatial Relations			
VR	Verbal Reasoning			
NA	Numerical Ability			
LU	Language Usage			
WK	Word Knowledge			
PSA	Perceptual Speed and Accuracy			
MSD	Manual Speed and Dexterity			

Enclosed with this report is a print-out of scores including Percentile Scores and those Occupational Clusters within which scores are high enough to consider them as potential areas for career exploration, dependent of course on expressed vocational interests and work values.

Also enclosed with the print-out are estimated scores on the General Aptitude Test Battery (GATB), as well as interpretive aids and statements useful in career counseling and exploration.

CCOPS.TXT

As an aid in vocational planning the California Career Occupational Preference System was utilized. The CCOPS is comprised of a vocational aptitude measure (CAPS), an interest inventory (COPS), and a work values inventory (COPES). Specific vocational aptitudes are plotted against expressed interests and work-related values in the context of 14 major occupational cluster areas. These occupational cluster areas range from the Professional Science area to that of Service occupations and have been successfully correlated with the General Aptitude Test Battery and its resultant Occupational Aptitude Patterns. Scores are expressed as Stanines (1-9, with 9 being the highest score obtainable) and as Percentiles; those above the 75th Percentile and below the 25th Percentile are judged to be particularly relevant in the overall interpretation of test results.

CLERICAL

Clerical occupations involve recording, posting and filing of business records requiring great attention to detail, accuracy, neatness, orderliness and speed. They include office work and contact with customers in keeping records. Sample occupations include Medical Secretary, Data Processor, Payroll Clerk, and Cashier.

COMMUN.ORL

COMMUNICATION, Oral occupations involve activities concerned with skill in the use of spoken language and the oral interpretation and communication of knowledge and ideas. Sample occupations include Lawyer, Radio or Television News Director and Announcer.

COMMUN.WRI

COMMUNICATION, Written occupations involve activities concerned with skill in the use of written language especially in the creation or interpretation of literature and the written communication of knowledge and ideas. Sample occupations include Copy Writer, Editorial Assistant, Librarian, Technical Writer, Editor, and Reporter.

COMMUNIC.SHN

Communication occupations involve language skill in the creation or interpretation of literature, or in the written and oral communication of knowledge and ideas. Sample occupations include Library Assistant, Technical Writer, and Communications Center Operator.

COMPUT

COMPUTATION occupations involve activities concerned with statistical analysis and use of mathematics and computation in research and business. Sample occupations include Actuary, Financial Analyst, Computer Programmer, and Statistician.

CONSUMER.ECO

Consumer Economics occupations involve the preparation and packaging of foods and beverages. They also include the production and care of clothing and textile products. Sample occupations include Dietetic Technician, Food Service Supervisor, and Dry Cleaner.

COPES.TXT

The Career Orientation Placement and Evaluation Survey (COPES) was administered in order to assess those personal values which have been repeatedly demonstrated to reflect major dimensions of job satisfaction. In conjunction with interests, what one would "like" to do, those domains which one values or perceives as important and worthwhile play an important role in career choice and job satisfaction. Work values measured by the COPES are described below.

INVESTIGATIVE vs. ACCEPTING: Intellectual curiosity and the challenge of solving a complex task are major values of persons scoring high on this scale. The need for information is very important to such people. Low scorers value clear cut activities in which they see the concrete results of their work and do not need to solve many complex problems.

PRACTICAL vs. CAREFREE: Showing proper appreciation for one's personal belongings and appreciation of practical and efficient ways of doing things are major values of persons scoring high on this scale. Such persons value activities in which they take good care of their property and work with things to make them more practical and efficient. Low scorers value activities where others take care of equipment and keep things in good working order.

INDEPENDENCE vs. CONFORMITY: Independence from rules, regulations, and social conventions, and the freedom to work on their own are major values of persons scoring high on this scale. Such persons value activities in which they are relatively free of rules and regulations and are not restricted by social obligations. Low scorers value working under careful supervision where clear directions and regulations can be followed.

LEADERSHIP vs. SUPPORTIVE: Making decisions, directing others, and speaking for the group are major values of persons scoring high on this scale. Such persons have a need to be seen as important and usually take positions of leadership. Low scorers value activities in which they can be a good follower and do not need to direct others or tell others what to do.

ORDERLINESS vs. NON-COMPULSIVE: Orderliness and keeping things neat and in their proper place are major values of persons scoring high. Such persons value activities in which they keep things tidy and do what they are expected to do. Low scorers value activities in which they can take things as they come and do not need to keep things orderly.

RECOGNITION vs. PRIVACY: To become well known and famous and to know important people are major values of persons scoring high on this scale. Such persons seek the admiration of others, as well as the rewards of honorary degree. Low scorers value keeping their activities private and are not concerned with being considered a famous person.

AESTHETIC vs. REALISTIC: Artistic appreciation and the enjoyment of music and the arts are major values of persons scoring high on this scale. Such persons value activities in which they appreciate beauty, show artistic and emotional sensitivity, and appreciate music and the arts. Low scorers value activities in which they do not rely on their senses and in which they are not involved with appreciation of artistic qualities.

SOCIAL vs. SELF-CONCERN: Helping others and appreciating the work of charitable service groups are major values of persons scoring high on this scale. Working with people in a friendly situation is important to such persons. Low scorers value activities in which they spend time on their own projects and tend to their own affairs rather than helping others.

Work and/or activity which incorporates value preferences is seen to be intrinsically worthwhile and indicative of job satisfaction for the majority of individuals. The work related values which are most important to are listed below; preference for the underlined work value is indicated by percentile rank.

Work Value Scale	Percentile Rank
Investigative vs. Accepting	
Practical vs. Carefree	
Independence vs. Conformity	
Leadership vs. supportive	
Orderliness vs. Non-Compulsive	
Recognition vs. Privacy	
Aesthetic vs. Realistic	
Social vs. Self-Concern	

COPS

The COPS is a self-report measure which allows the individual to select and more carefully define the kind of work which he/she may be interested in doing. Choices are given regarding a variety of activities which are performed and/or are a part of many and diverse occupations. The individual is asked to make choices based on personal interests rather than on consideration of factors such as salary, social standing, or future advancement. These many activities are then categorized with respect to the fourteen occupational clusters detailed in the CCOPSystem and reported as percentile ranks. __________'s highest reported vocational interest areas fall under the career clusters of:

	Percentile
1.	
2.	
3.	
4.	
5.	

COPS-P

The COPS-P is a self-report measure which allows the individual to select and more carefully define the kind of work which he/she may be interested in doing. Choices are given regarding a variety of activities which are performed and/or are a part of many and diverse occupations. The individual is asked to make choices based on personal interests rather than on consideration of factors such as salary, social standing, or future advancement. These many activities are then categorized with respect to the sixteen professional-level occupational clusters detailed in the CCOPSystem and reported as percentile ranks. 's highest reported vocational interest areas fall under the career clusters of:

	Percentile
1.	
2.	
3.	
4.	
5.	

COPSP.II

The COPSP is a self-report measure which allows the individual to select and more carefully define the kinds of work which he/she may be interested in doing. Choices are given regarding a variety of activities which are performed and/or are a part of many and diverse professional or college-oriented occupations. The COPSP yielded the following percentile levels of interest across 16 major professional-level occupational clusters.

Career Group	Percentile
1 Science, Medical-Life	
2 Science, Physical	
3 Technology, Electrical	
4 Technology, Mechanical	
5 Technology, Civil	
6 Outdoor, Nature	
7 Outdoor, Agribusiness	
8 Business, finance	
9 Business, Management	
10 Computation	
11 Communication, Written	
12 Communication, Oral	
13 Arts, Performing	
14 Arts, Design	
15 Service, Instructional	
16 Service, Social	

DTLA.TAB

The third edition of the Detroit Tests of Learning Aptitude (DTLA-3) is designed as a battery to measure a variety of developed abilities, a term coined by Anastasi to convey a means of looking at the fundamental similarities between traditional achievement and aptitude tests and specifically focusing on discrete, special abilities which underlie the learning process. The DTLA-3 is a battery of 11 subtests that measure different but interrelated mental abilities. In addition to the 11 subtests, a General Mental Ability Compositive scores can be derived from combining the standard scores of all 11 subtests. An Optimal Level Composite score can also be derived by looking at the four largest standard scores made by the individual on the subtests. Finally, three Domain scores are derived: Linguistic (Verbal and Nonverbal); Attentional (Attention-enhanced--concentration and short term memory; Attention-reduced--long term memory); and Motoric (Motor-enhanced--complex manual dexterity; Motor-reduced--motor free, oral or pointing responsivity). Thus, results from the DTLA-3 are useful in describing an individual's relative strengths and weaknesses, an adjunct to intelligence testing, and as a predictive measure of future performance.

's scores on the DTLA-3 are as follow:

GENERAL MENTAL ABILITY
OPTIMAL
LINGUISTIC
    VERBAL
    NONVERBAL
ATTENTIONAL
    ENHANCED
    REDUCED
MOTORIC
    ENHANCED
    REDUCED

DYSEIDET.RDR

Dyseidetic readers show strengths in the auditory analytic function and weaknesses in the visual gestalt function. They show a deficit in visual memory and perception for letters and whole words, with resulting disability in developing a sight vocabulary. Their typical reading errors are phonetic misreadings of nonphonetic words ("lowg" for laugh) and visuospatial reversals of reversible letters and words ("dig" for big, "was" for saw). Their typical spelling errors are good phonetic equivalents of the dictated words. Dyseidetics read slowly, as if seeing each word for the first time. Unlike dysphonetic readers, who have difficulty learning what the letters sound like, dyseidetic readers have poor memory for the visual configurations of letters and words and thus have difficulty learning what the letters look like. They are analytic readers and read by ear rather than by whole-word configurations. They read laboriously, sounding out familiar as well as unfamiliar combinations of letters. Dyseidetic readers, like dysphonetic readers, spell poorly but not bizarrely. They spell as they read - by ear. Thus their typical misspellings are phonetically accurate, and the original words can usually be recognized. Their occasional phonetically inaccurate or bizarre misspellings of nonphonetic words seem to be the result of their efforts to spell words in their sight vocabularies by revisualizing them and thus failing to make use of their more efficient auditory channel.

DYSPHO.RDR

Dysphonetic readers show strengths in the visual gestalt function and weaknesses in the auditory analytic function. They have difficulty integrating symbols with their sounds, and as a result they are unable to develop phonic decoding skills without remedial instruction. Dysphonetic readers typically have a function though relatively limited sight vocabulary of whole words that they recognize on flash presentation and read fluently. They read words globally, as whole-word gestalts, rather than analytically. No matter how common or phonetic a word may be, if it is not yet in their sight vocabulary, they are typically unable to decipher it. They may have learned the fundamental sound-symbol associations, but they lack phonic word-analysis skills; they are still unable to sound out and blend the component letters and syllables of a word and offer more misreadings than either of the other two dyslexic subtypes. They may guess at a word from minimal graphic clues, typically from the first and last letter and the length of the word, resulting in global or gestalt substitutions such as "monkey" for money and "stop" for step. Their most striking substitutions--which occur primarily in reading but also in spelling--are semantic substitutions. These words are similar in meaning to the original words but are unlike them phonetically; for example, "person" may be substituted for human and "airplane" for train. Semantic substitutions are so characteristic in this group of dyslexics that they are virtually diagnostic.

Dysphonetic readers attempt to spell by sight alone and not by ear, for they have difficulty in learning what the letters sound like. They cannot spell phonetically because they cannot read phonetically. Just as they are typically unable to analyze the visual gestalt of a written word, they are unable to analyze, or segment, a spoken word (the auditory gestalt) into its component sounds and syllables; that is, they are unable to syllabicate. Their misspellings are therefore phonetically inaccurate and include such errors as extraneous letters, omitted syllables, auditory discrimination errors, syllable reversals, letter-order errors, and other auditory sequencing errors. They spell correctly to dictation only those words in their sight vocabularies that they can revisualize, phonetic or not. These words seldom total as much as 50 percent of their sight vocabulary at treading level and usually far less.

Visuospatial reversals, including letter reversals, mirror-reading and mirror-writing, are not characteristic of dysphonetic readers. Like normal beginning readers, they tend to overcome these errors before the age of eight, and they have no difficulty learning what the letters look like. They do tend to persist, however, in making syllable and letter-order reversals (for example, "interver" for inventor and "wirters" for writers), though they do this less in reading than in spelling.

GATB.TXT

The General Aptitude Test Battery (GATB) is a multiaptitude test battery for use in vocational counseling and guidance. The following interpretive statements should assist the individual to understand current vocational aptitude scores and how these relate to a wide variety or groups of occupations. It must be noted that this instrument does not take into account any other factors which figure in occupational success, such as educational or training requirements, social skills, or specific work-related stressors.

Listed below are the letters used as the symbol to identify each aptitude and the definitions of the nine aptitudes measured by the GATB:

	APTITUDE
G	General Learning Ability - The ability to "catch-on" or understand instructions and underlying principles; the ability to reason and make judgments. Closely related to doing well in school (formal educational settings).
V	Verbal Aptitude - The ability to understand the meaning of words and to use them effectively. The ability to comprehend language, to understand relationships between words, and to understand meanings of whole sentences and paragraphs.
N	Numerical Aptitude - The ability to understand and perform arithmetic operations quickly and accurately.
S	Spatial Aptitude - The ability to think visually of geometric forms and to comprehend the two-dimensional representation of three-dimensional objects. The ability to recognize the relationships resulting from the movement of objects in space.
P	Form Perception - The ability to perceive pertinent detail in objects or in pictorial or graphic material. The ability to make visual comparisons and discriminations, and to see slight differences in the shapes and shadings of figures, widths, and lengths of lines.
Q	Clerical Perception - The ability to perceive pertinent detail in verbal or tabular material. The ability to observe differences in copy, to proofread words and numbers, and to avoid perceptual errors in arithmetic computation. Also a measure of speed of perception.
K	Motor Coordination - The ability to coordinate eyes and hands or fingers rapidly and accurately in making precise movements with speed. The ability to make a movement response accurately and swiftly.
F	Finger Dexterity - The ability to move the fingers, and manipulate small objects with the fingers, rapidly or accurately.
M	Manual Dexterity - The ability to move the hands easily and skillfully. Ability to work with the hands in placing and turning motions.

Aptitude scores may be broadly interpreted according to the following scale:

APTITUDE SCORE	RANGE
120 and above	High
76-119	Medium
75 and below	Low

The GATB aptitude norms for use in counseling and guidance are referred to as Occupational Aptitude Patterns (OAPs). An OAP may be defined as "The combination of aptitudes and minimum scores required to perform satisfactorily the major tasks of each occupation identified with each pattern". OAPs are the means by which individual aptitude scores are related to broad fields of work in which aptitudinal requirements are similar, even though the specific jobs may appear to be totally unrelated.

The OAPs, or groups of jobs, are numbered 1-66. The 66 OAPs cover 97% of the non-supervisory occupations listed in the Guide for Occupational Exploration (U.S Department of Labor, 1979). The interpretation of OAP as High, Medium, or Low is as follows:

HIGH	The individual's scores equal or exceed those of workers judged to be satisfactory in the occupations. If also qualified on the basis of factors other than aptitudes, there is a good probability that he/she will do well on the job.
MEDIUM	The individual's scores are close to those of workers judged to be satisfactory in the occupations. However, the chances of doing well on the job are somewhat lower than that of persons in the "High" category.
LOW	The individual's scores are similar to or below those of workers found to be unsatisfactory in the occupation. Barring other factors, the probability of being satisfactory on the job is low, and he/she should be considered for other jobs which utilize stronger aptitudes.

It must be noted that since the OAP scores are not specifically determined, they should be considered as guidelines.

GATESK.TAB

GATES-MACGINITIE READING TEST
(Level 10/12, Form K)

	Stanine	Percentile Rank
Comprehension		

GATESL.TAB

GATES-MACGINITIE READING TEST
(Level 10/12, Form L)

	Stanine	Percentile Rank
Comprehension		

GORT

An additional measure of reading, the Gray Oral Reading Test was also administered. With this diagnostic measure various reading errors and speed of reading are evaluated. The difficulty of the reading passages utilized is a function of the difficulty of vocabulary, range and density of vocabulary, syllabic length of words, length and complexity of sentence structure, and maturity of concepts.

HRNB.1

A comprehensive neuropsychological evaluation was then undertaken utilizing the Halstead Reitan neuropsychological battery and ancillary procedures. Test data were analyzed using norms developed by Heaton, Grant and Matthews (1991) and permit demographic-corrected score conversion. This allows the individual's test performances to be compared with an appropriate normative peer group which is matched for gender, age, and level of education. In addition, the HRNB provides a number of means to differentiate the presence or absence of cerebral dysfunction involving "cutting-score" criteria. The Impairment Index, a ratio score derived from the number of scales above or below a critical score criterion indicative of brain damage offers a range of scores between 0 and 1.0. Scores below .4 are generally considered within normal limits.

HRNB.2

A comprehensive neuropsychological evaluation was then undertaken utilizing the Halstead Reitan neuropsychological battery and ancillary procedures. Test data were analyzed using norms developed by Heaton, Grant and Matthews (1991) and permit demographic-corrected score conversion. This allows the individual's test performances to be compared with an appropriate normative peer group which is matched for gender, age, and level of education. In addition, the HRNB provides a number of means to differentiate the presence or absence of cerebral dysfunction involving "cutting-score" criteria. The Impairment Index, a ratio score derived from the number of scales above or below a critical score criterion indicative of brain damage offers a range of scores between 0 and 1.0. Scores below .4 are generally considered within normal limits. A more refined methodology, the General Neuropsychological Deficit Score, involves the use of severity ratings in the differentiation of the presence or absence of brain damage. Here, scores between 0-25 are considered fully normal and scores 26-40 indicative of mild neuropsychological impairment. Profile analysis available with the HRNB provides a means to associate the performance with specific functional or neuroanatomical correlates.

HRNB.TXT

A comprehensive neuropsychological evaluation was then undertaken utilizing the Halstead Reitan neuropsychological battery and ancillary procedures. Test data were analyzed using norms developed by Heaton, Grant and Matthews (1991) and permit demongraphic-corrected score conversion. This allows the individual's test performances to be compared with an appropriate normative peer group which is matched for gender, age, and level of education. In addition, the HRNB provides a number of means to differentiate the presence or absence of cerebral dysfunction involving "cutting-score" criteria. The Impairment Index, a ratio score derived from the number of scales above or below a critical score criterion indicative of brain damage offers a range of scores between 0 and 1.0. Scores below .4 are generally considered within normal limits. A more refined methodology, the General Neuropsychological Deficit Score, involves the use of severity ratings in the differentiation of the presence or absence of brain damage. Here, scores between 0-25 are considered fully normal and scores 26-40 indicative of mild neuropsychological impairment. Profile analysis available with the HRNB provides a means to associate the performance with specific functional or neuroanatomical correlates.

INVAL.TXT

Poor investment, limited attention and minimal tolerance all combined to yield substantial confounds to the validity for interpretive purpose of the obtained assessment results. As such, while comments on the general psychometric pattern of relative strengths and weaknesses are possible, the reader is cautioned that these data may underestimate this individual's true potential in those areas assessed.

ISP

Summary of Personal
Resources, Skills,
Strengths

Summary of Missing or Inadequate
Personal Resources, Deficits,
Limitations

Summary of Resources
Needed to Accommodate,
Ameliorate, or
Overcome Problem
Areas

JORDAN

The Jordan Left-Right Reversal Test is a norm referenced measure which assesses visual reversals of letters, numbers, and words in individuals from five years of age through adulthood. Obtained error scores are converted to percentile scores related to expected levels of performance.

LBNOR

The derived profile was fully normal, suggesting no evidence of structurally based cerebral dysfunction. There were no focal or lateralizing signs of impairment and no indices suggestive of acute acquired cerebral dysfunction were discerned.

Briefly summarized, in the primary sensory-perceptual sphere, intact performance was seen in auditory, visual, and tactile-haptic processing. In terms of psychomotor performance, basic coordination and speed were intact. Augmentation of the battery in visuospatial and constructional skill domains revealed no particular problem area. Aphasia screening revealed no expressive or receptical language problems. Memory proficiency was fully normal.

LINGUIST.TXT

Linguistic Faculties:

There were no specific dysphasic features apparent in our assessment of receptive and expressive language. Articulation and speech prosody were normal. There were some errors noteworthy in the pragmatic usage of language (grammar and syntax), but these were not uncharacteristic of the type seen in patients with limited literacy skills.

LNNB.TXT

The neuropsychological portion of the examination was conducted via the administration of the Luria-Nebraska and ancillary procedures. The Luria-Nebraska Battery provides an age and education adjusted profile of performance across fourteen domains deemed relevant to the assessment of higher cortical functioning. No focal or lateralizing signs of specific cerebral dysfunction were identified.

M
M̄

MBTI

The Myers-Briggs Type Indicator (MBTI) is a personality survey which is primarily concerned with identifying the basic preferences of people in regard to perception, judgement, incorporating information, and making decisions.

There are two opposite preferences for each of the four scales reported by the MBTI. It is important to realize that everyone uses both of the opposite preferences at different times, but not both at once, and in most cases, not with equal confidence. The four scales and preferences are briefly defined below.

EI scale:	Where does one prefer to focus his/her attention?
Extroversion (E)	- focus on the outer world of people and things.
Introversion (I)	- focus on one's inner world.
SN scale:	How does one acquire information, or find out about things?
Sensing (S)	- focus on the realities of a situation, work with known facts.
Intuition (N)	- focus on meanings, relationships, and possibilities that go beyond the information from one's senses.
TF scale:	How does one make decisions?
Thinking (T)	- objectively, on the basis of cause and effect, by impersonally analyzing the evidence.
Feeling (F)	- subjectively, on the basis of person-centered and personal values.
JP- scale:	How does one orient the outer world?
Judging (J)	- like to live in a planned, orderly way, wanting to regulate life and control it.
Perceiving (P)	- like to live in a flexible, spontaneous way, gathering information and keeping options open, seeking to understand life rather than control it.

_____ indicated preferences for the following type:

_______'s preferences on the MBTI are ______ with his/her preferences on the COPES. Enclosed with this report is a more extensive interpretive aid on the MBTI and ____preferences. ________ types do best in careers needing _____, _____, and _______. Examples include: ______________.

MCMI-II.TXT

The MCMI-II, a multiaxial inventory measure comprised of twenty clinical scales, was designed to distinguish the more enduring personality characteristics of patients (Axis II) from the acute clinical disorders categorized under Axis I as well as measure the severity of clinical syndromes present. Cutting scores are used to make decisions concerning primary behavior disorders or syndrome diagnoses and elevations among subsets of scales can provide information regarding level of impairment, severity, and chronicity of the disorder.

MDRS-N-S

MDRS-N-S

The Mattis Dementia Rating Scale (DRS) screens five major domains of cognitive function, yielding composite scores for each of the subtests as well as a total test score. The subject's scores/performances on each of these variables can then be compared to peer reference data available for normal controls and those who carry diagnoses of Senile Dementia of the Alzheimer's-type (SDAT). The data obtained with is noteworthy on several counts, and these will be explored from general through specific levels of interpretation.

A composite test score of was obtained, (placing below the actuarial cut-off score of 123) suggesting that a diagnosis of dementia may apply. What is most interesting, however, is to review the strengths and weaknesses across the subtests and contrast these with existing normative data.

	NORMAL CONTROL			SDAT NORMS	
	RAW	MEAN	SD	MEAN	SD
Attention		35.5	1.6	23.55	9.91
Initiation/Perseveration		35.5	3.0	21.37	9.78
Construction		5.8	0.6	2.55	1.81
Conceptualization		37.2	2.6	21.18	10.58
Memory		23.3	2.1	10.91	6.58
DRS Total		**137.3**	**6.9**	**79.55**	**33.98**

MDRS.DEM

The Mattis Dementia Rating Scale (DRS) screens five major domains of cognitive function, yielding composite scores for each of the subtests as well as a total test score. The subject's scores/performances on each of these variables can then be compared to peer reference data available for normal controls and those who carry diagnoses of Senile Dementia of the Alzheimer's-type (SDAT). The data obtained with is noteworthy on several counts, and these will be explored from general through specific levels of interpretation.

A composite test score of was obtained, (placing below the actuarial cut-off score of 123) suggesting that a diagnosis of dementia may apply. What is most interesting, however, is to review the strengths and weaknesses across the subtests and contrast these with existing SDAT norms.

MATTIS DEMENTIA RATING SCALE

		SDAT NORMS	
	RAW	MEAN	SD
Attention		23.55	9.91
Initiation/Perseveration		21.37	9.78
Construction		2.55	1.81
Conceptualization		21.18	10.58
Memory		10.91	6.58
DRS Total		**79.55**	**33.98**

MDRS.NOR

The Mattis Dementia Rating Scale (DRS) screens five major domains of cognitive function, yielding composite scores for each of the subtests as well as a total test score. The subject's scores/performances on each of these variables can then be compared to peer reference data available for normal controls and those who carry diagnoses of Senile Dementia of the Alzheimer's-type (SDAT). The data obtained with is noteworthy on several counts, and these will be explored from general through specific levels of interpretation.

A composite test score of was obtained, (placing below the actuarial cut-off score of 123) suggesting that a diagnosis of dementia may apply. What is most interesting, however, is to review the strengths and weaknesses across the subtests and contrast these with existing norms for a "normal" control group.

MATTIS DEMENTIA RATING SCALE

NORMAL CONTROL

	RAW	MEAN	SD
Attention		35.5	1.6
Initiation/Perseveration		35.5	3.0
Construction		5.8	0.6
Conceptualization		37.2	2.6
Memory		23.3	2.1
DRS Total		137.3	6.9

MMPI.INV

An attempt was made to potentially contribute to diagnostic formulations regarding this individual's psychiatric status by administering an abbreviated version of the Minnesota Multiphasic Personality Inventory. In short, the MMPI profile was not viewed as valid for interpretive purposes. The item endorsement pattern suggested an extreme overstatement of unusual symptoms, feelings, and/or experiences. The magnitude of disturbance implicated through the responses was so severe that the likelihood that this represents bonafide psychopathology is very slim. Such an overstatement of psychologic distress may be the result of multiple situations or dynamics. For some individuals, it is possible that the test queries were misunderstood or that they were careless in responding to render a somewhat haphazard item endorsement. For others, such an extreme portrayal may represent a plea for psychological help. Finally, the possibility of malingering must be considered it there is reason to believe that secondary gains could be derived from such severe emotional disturbance.

MMSMB.TXT

Personality assessment was conducted via use of the Minnesota Multiphasic Personality Inventory - II (MMPI-II), the Millon Clinical Multiaxial Inventory - II (MCMI-II), the SCL-90-R, the Multidimensional Self-Esteem Inventory (MSEI), and the Beck Depression Inventory (BDI).

NELSON.TAB

	Standard Score	Percentile Rank	Stanine
Reading Comprehension			
Reading Rate			

OUTDOOR

Outdoor occupations involve activities performed primarily out of doors. They include the growing and tending of plants and animals and the cultivation and gathering of crops and natural resources in the areas of agriculture and nature as in forestry, park service, fishing and mining. Sample occupations include Nursery Laborer, Soil Conservationist, and Park Ranger.

OUTDOOR.AGR

OUTDOOR, Agribusiness occupations involve activities performed primarily out-of-doors which are concerned with the growing, tending and harvesting of plants and animals for human consumption. Sample occupations include Dairy Technologist, Farmer, Horticulturist, Soil Conservationist, and Range Manager.

OUTDOOR.NAT

OUTDOOR, Nature occupations involve activities performed primarily out-of-doors which are concerned with the protection, accumulation and harvesting of natural resources. Sample occupations include Derrick Operator, Fish and Game Warden, Forester, Oceanographer and Ecologist.

PERFORM

PERFORM

PERFORMANCE SUBTEST DESCRIPTIVES FOR:

PICTURE COMPLETION
PICTURE ARRANGEMENT
BLOCK DESIGN
DIGIT SYMBOL
OBJECT ASSEMBLY

PC

a measure of concentration and the ability to differentiate essential from nonessential details

PA

the ability to interpret social situations and nonverbal reasoning ability

BD

a measure of visual-motor coordination and spatial visualization

DS

a measure of speed of mental operations and visual-motor coordination

OA

visual motor coordination and perceptual organizational ability

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RHEMSOC.SYN

Perceptual deficits associated with a right hemisphere syndrome may render the individual at further disadvantage in the realm of social understanding and behavior. Cognitive/perceptual deficits may result in deficiencies in the ability to interpret/understand nonverbal sources of communication (such as subtle facial expressions, body postures, various gestures, etc.). Consequentially, this individual may be at further risk for misinterpreting or failing to interpret relevant elements in social situations as well as the environment at large. Subtle interpersonal nuances pertinent for effective relating skills may not be present (such as appreciating the others' personal space; perceiving appropriateness in timing and length of dialogue). Additionally, poor social reception may be related to these variables as well as the somewhat unusual prosody of speech.

The individual's inefficacy in "sizing up" situations (both socially and personally), may result in reliance upon very concrete and routinized self-monitoring skills. The consequences could be manifested in ways such as poor management of personal affairs, inadequate maintenance of impulse controls, and the limited capacity/potential for changing maladaptive behaviors.

S-B1.TAB

The Stanford-Binet Intelligence Scale: Fourth Edition was utilized to assess general intellectual functioning. Presented below are the Standard Age Scores (SAS's) that were derived for each general domain and the Test Composite Score, all of which are based on a mean of 100 and Standard Deviation of 16.

Verbal Reasoning SAS
Abstract/Visual Reasoning SAS
Quantitative Reasoning SAS
Short-Term Memory SAS

Further analysis of cognitive strengths and weaknesses within each of the general domains is available through review of performance levels across the various subtests of the Stanford-Binet: Fourth Revision all of which have a mean of 50 and a Standard Deviation of 8.

Verbal Reasoning Subtests

- Vocabulary
- Comprehension
- Absurdities
- Verbal Relations

Abstract/Visual Reasoning Subtests

- Pattern Analysis
- Copying
- Matrices
- Paper Folding and Cutting

Quantitative Reasoning Subtests

- Quantitative
- Number Series
- Equation Building

Short-Term Memory Subtests

- Bead Memory
- Memory for Sentences
- Memory for Digits
- Memory for Objects

SCIENCE.LIF

SCIENCE, Medical- Life occupations involve activities concerned with the conducting of research and the accumulation and application of systemized knowledge in medicine and the biological and life sciences. Sample occupations include Anesthesiologist, Pharmacologist, Physiatrist, Geneticist, and Biomedical Engineer.

SCIENCE.PHY

SCIENCE, Physical occupations involve activities concerned with the planning and conducting of research and the accumulation and application of systemized knowledge of the physical world in the earth sciences. Sample occupations include Chemist, Physicist, Pharmacist, Geologist and Research Dietician.

SCIENCE.PRO

Professional Science occupations involve responsibility for the planning and conducting of research and the accumulation and application of systematized knowledge in related branches of mathematical, medical, life and physical sciences. Sample occupations include Actuary, Chemist, Pharmacologist, and Programmer.

SCIENCE.SKL

Skilled Science occupations involve observation and classification of facts in assisting in laboratory research and it's application in the fields of medicine and life and physical sciences. Sample occupations include Surgical Technician, Dental Assistant, Hygienist, Pharmacy Helper, and Meter Reader.

SCII

A second measure of occupational interest was utilized to further explore ______'s career interests. The Strong-Campbell Interest Inventory (SCII) yields systematic information about patterns in one's vocational interests and how these patterns compare with those of successful people in many occupations. Results are based on interests, not aptitudes or abilities. Indicated likes and dislikes are analyzed in three main ways: 1) "General Occupational Themes" for similarity to six important overall patterns; 2) "Basic Interest Scales", for similarity to 23 clusters of specific activities; and 3) "Occupational Scales", for similarity to the interests of men and woman successfully employed in 106 occupations.

Found below is ___________'s profile on the General Occupational Themes of the SCII. The range of scores is roughly from 30 to 70, with the average person scoring 50.

GENERAL OCCUPATIONAL THEME	SCORE	RANGE
Realistic		
Investigative		
Artistic		
Social		
Enterprising		
Conventional		

Of the 23 Basic Interest Scales of the SCII, _____'s interest reached average or higher on the following scales:

BASIC INTEREST SCALE	SCORE	RANGE

_____'s responses were very similar or similar to those of persons working in occupations corresponding to ________of the 106 Occupational Scales of the SCII.

There are two Special Scales on the SCII designed to yield additional insight into interests and expectations. The Academic Comfort Scale differentiates between people who enjoy being in an academic setting and those who do not. Persons with low scores (below 40) often are inclined to view education as a necessary hurdle for entry into a career, whereas persons with high scores (above 50) typically seek out academic courses. _____ score of ___ on this scale indicated a __________ inclination/disinclination toward formal academic coursework. The Introversion-Extroversion Scale is associated with a preference for working with things or ideas (scores above 55) or with people (scores below 45). ____ score of ____ on this scale indicates a _________ preference for working ____ ______.

Enclosed with this report is _____comprehensive SCII Profile Report and further interpretive information.

SCL.90

The SCL-90-R is a 90-item self-report symptom inventory which yields a profile based upon nine primary symptom dimensions labeled Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism.

SENSORY.TXT

Sensory-Perceptual Faculties:

In terms of basic tactile-haptic skills, there was no evidence of impairment in the ability to discriminate stimuli delivered to the skin. Finger localization, point and pressure sensitivity, and two-point discrimination were readily demonstrated. As soon as a symbolic demand became associated with the interpretation of tactile stimuli (drawing shapes or alphanumeric symbols on the skin or discriminating objects placed in the hand) performance became obviously less efficient.

In the auditory modality, there was no evidence of any loss in primary acoustical or phonemic discrimination skills. With increasing complexity of auditory stimuli, however, especially the processing of lengthy spans of sequential auditory information, performance immediately faltered. We emphasize that we were not impressed with evidence of "attentional impairment". Rather, there appears to be evidence of central information processing difficulties. This individual appears limited in the amount and complexity of information which can be acted upon and sequentially processed.

SERVICE.INS

SERVICE, Instructional occupations involve activities concerned with the instruction of techniques in interpersonal relations especially in caring for the personal needs and welfare of others in the field of education. Sample occupations include Teacher, Coach, and Director of Student Affairs.

SERVICE.PRO

Professional Service occupations include positions of high responsibility in caring for the personal needs and welfare of others in fields of social service, health and education. Sample occupations include Teacher, Counselor, and Nurse/Physician.

SERVICE.SKL

Skilled Service occupations involve providing services to persons and catering to the tastes, desire and welfare of others in fields of personal service, social and health related services, and protection and transportation. Sample occupations include Housekeeping, Home Health Aide, and Security Guard.

SERVICE.SOC

SERVICE, Social-Health occupations involve activities concerned with interpersonal relations in caring for the personal needs and welfare of others in fields of social service and health. Sample occupations include Nurse, Counselor, Speech Pathologist, Probation Officer, and Recreational Therapist.

SPEECH.TXT

Expressive speech evidences an articulation disorder as well as an unusual tonal quality and flow. These deficits are not, however, conceptualized as classic "left hemisphere" language problems but rather, components of the suspected right hemisphere syndrome. The same motor lags creating slowing and incoordination in the contralateral hand could also result in the developmental articulation problems evidence. The demonstrated prosodic abnormalities are equally interesting and impressive within the conceptualized formulation of right hemisphere dysfunction. Specifically, this is described in the literature as frequently associated with right hemisphere pathology since prosody relies upon affective expression and rhythmic appreciation. There is a body of literature to support that mediation of both may integrally involve right more than left hemisphere regions.

SR1

_______________ was given information regarding services available from the Office of Vocational Rehabilitation (OVR) and was instructed to contact OVR directly if OVR fails to contact him/her within three weeks of hospital discharge.

SR2

No follow-up is planned in NARS at this time as outpatient treatment will be non-catchment at WPIC as per Institute policy.

SR3

_______________ would be a good candidate for vocational skill training. Any training program under consideration should be evaluated in terms of necessary reading skills. _______________ would probably do best in jobs/training that emphasize hands-on rather than textbook learning.

SR4

_______________ could benefit from job seeking skills training, support and assistance.

SR5

_______________ is a good candidate for job placement assistance.

SR6

______________ will be receiving outpatient treatment through _______, therefore, no follow-up is planned in NARS at this time.

SR7

______________ is seen in the NARS clinic twice per month on an outpatient basis. He/she has been referred to the Office of Vocational Rehabilitation (OVR) and liaison services will continue.

SR8

As the patient has expressed an interest in attending college, consideration should be given to California University of Pennsylvania's specialized programs for students with learning disabilities, which include summer programs for high school juniors and seniors, as well as an Associate Degree program.

SR9

Consideration may also be given to the specialized instruction and "survival skills" training for the learning disabled available through the Association for Learning Disabilities.

SR10

______________ should be referred to the Office of Vocational Rehabilitation (OVR) in order to establish eligibility and to facilitate further vocational counseling and subsequent financial sponsorship in programming.

SR11

It is recommended that ______________ continue to explore the nature of careers of interest as well as various related college programs of study and curriculum choices.

SR12

____________ could gain exposure and practical experience through informational/site interviews, and working as a volunteer or part-time in a ___________ setting.

SR13

_____________ may benefit from experiencing one or two courses representative of the core curriculum of high interest careers. These could be taken on a non-credit/"leisure learning" basis or for credit.

SR14

The patient may wish to consider Community College of Allegheny County's (CCAC) Learning Disabled "Block" Program, in which students with learning disabilities take classes in remedial math, English, and reading, as well as word processing, study and survival skills, and career development.

SR15

The patient could benefit from assistance in improving college study, test-taking, and related "survival skills" in order to better meet the overall demands of formal academic coursework.

SR16

Functional interference from the patient's longstanding psychiatric disorder is likely to be more problematic than any primary cognitive deficits.

SR17

A slightly lower performance was observed in the area of ____but would not be judged as a significant area of deficit. However, the patient may need support in the aspects of ___ educational/training program that may require ____skills beyond current level of achievement.

SR18

Several issues appear likely to figure prominently in ________ attempt to enhance his/her vocational skills and employment status. As he/she must maintain him/herself financially while undergoing vocational skill training, and as he/she does not wish to leave his/her current daylight job due to comfort level and anxiety around any job change, skill training programs should be investigated with are part-time in nature, offered in the evenings, or are paid in nature.

SR19

________could benefit from ongoing professional rehabilitation assistance in exploring potential programs of study/training. Additionally, he/she lacks knowledge and experience in accessing even the standard types of student financial aid which are available to him/her.

SR20

_______could benefit from ongoing vocational counseling and guidance in an atmosphere of support and encouragement of efforts to enhance vocational and employment situations.

SR21

Strong and highly distinct patterns of occupational interest and preference emerged across all measures utilized in this assessment.

SR22

Measured aptitudinal strengths correspond to the nature and aptitudinal demands of _______'s measured and expressed high-interest career goals.

TECH.CIV

TECHNOLOGY, Civil-Construction occupations involve activities concerned with the structural design for construction of buildings, highways and other transportation systems. Sample occupations include Structural Drafter, Mining Engineer and Safety Engineer.

TECH.ELE

TECHNOLOGY, Electrical occupations involve engineering and systems design in the fields of electricity and electronics. Sample occupations include Computer Engineer, Electrical Test Engineer, and Electronic Design Engineer.

TECH.MEC

TECHNOLOGY, Mechanical occupations involve activities concerned with engineering and structural design of aircraft, automotive, marine and other mechanical equipment and the development of new and improved mechanical and chemical manufacturing processes for converting raw materials into products. Sample occupations include Materials Engineer, Tool Designer, Petroleum Engineer and Metallurgist.

TECHNOLO.PRO

Professional Technology occupations involve responsibility for engineering and structural design in the manufacture, construction or transportation of products or utilities. Sample occupations include Aeronautical Engineer, Marine Architect and Chemical Engineer.

TECHNOLO.SKL

Skilled Technology occupations involve working with one's hands in a skilled trade concerned with construction, manufacture, installation or repair of products in related fields of construction, electronics, and mechanics. Sample occupations include Brick Layer, Mechanic, Truck Driver, and Video Control-Room Technician.

TESTS

NAME OF TEST	MINUTES/TEST
Wechsler Adult Intelligence Scale - Revised (WAIS-R)	90
Wide Range Achievement Test - Revised (WRAT-R)	30
Halstead-Reitan Neuropsychological Battery (HRNB)	240
California Verbal Learning Test (CVLT)	40
Nelson-Denny Reading Test	20
Wechsler Memory Scale - Revised (WMS-R)	45
Raven Standard Progressive Matrices	15
Paced Auditory Serial Addition Test (PASAT)	10
Boder Test	20
Woodcock Johnson Test of Achievement-Revised	10
Stroop Color-Word Test	5
Rey-Osterrieth Complex Figure Drawing, Star Drawing Test, Hooper Visual Organization Test, Smith Symbol Digit Modalities Test	10
	535 = 8 hours, 55 min.

TOWL-2.TAB

The Test Of Written Language - 2 (TOWL-2) was used in order to measure written expressive language involving both writing per se and the expression of ideas as a form of communication. The ability to write meaningfully is based upon at least three basic cognitive skills: (1) the ability to write in compliance with accepted standards, especially those governing punctuation, capitalization, and spelling; (2) the ability to use acceptable syntactic, morphologic and semantic elements of a given language; and (3) the ability to express ideas, opinions, and thoughts in a creative and mature way. These three abilities comprise the conventional, linguistic, and conceptual components of writing. The TOWL-2 is a measure which attempts to evaluate these three abilities. With ________, the spontaneous story subtest was utilized. Here one can get a measure of thematic maturity, contextual vocabulary syntactic maturity, contextual spelling, and contextual style with results presented as percentile ranks and standard scores with a mean of 10. ______ scores on this subtest of the TOWL-2 follow:

	Percentile Rank	**Standard Score**
Thematic Maturity		
Contextual Vocabulary		
Syntactic Maturity		
Contextual Spelling		
Contextual Style		

TPT.TXT

The Tactile Performance Test is a measure of complex psychomotor ability involving problem solving without the use of the visual or auditory senses and relying on tactile cues only. Input is delivered to the brain via the haptic senses from the preferred hand to the contralateral cerebral hemisphere, where the incoming information is registered. Because of intracerebral and intercerebral connections, the incoming information permeates the entire brain, which then becomes involved in solving the problem. After a trial with the dominant hand, the individual is given the task to perform with the nondominant hand, with the expectation that the time required to solve the task should be reduced by one-third because learning transfer has occurred.

VINELAND.TAB

	Standard Score	Age Equivalent
Communication Domain		
Receptive		
Expressive		
Written		
Composite		
Daily Living Skills		
Personal		
Domestic		
Community		
Composite		
Socialization		
Interpersonal		
Play and Leisure		
Coping Skills		
Composite		

Motor Skills
  Gross
  Fine
  Composite

WAIS-R.TAB

Intellectual evaluation was conducted via the administration of the Wechsler Adult Intelligence Scale - Revised. This instrument provides a composite score (Full Scale IQ) which serves as an index of general intelligence as well as Verbal and Performance IQ scores. The results obtained were as follows:

Verbal IQ:
Performance IQ:
Full Scale IQ:

These scores are commensurate with functioning in the range of intelligence.

Further analysis of WAIS-R performance is available via subtest analysis. The Verbal Subtests consist of tasks which tap verbal conceptual ability, practical judgment and reasoning, numerical reasoning, immediate auditory attention, acquired knowledge, and general verbal proficiency. The Performance Subtests involve more visuoperceptual and visuomotor skills in task completion. Spatial and nonverbal reasoning skills are tapped in these tasks. In addition, demands are imposed for speed dependent performance on a number of these tests. Subtests are scored as Scaled Scores with a mean of 10 and a standard deviation of 3.

Verbal Subtests	Scaled Scores
Information	
Digit Span	
Vocabulary	
Arithmetic	
Comprehension	
Similarities	

Performance Subtests	Scaled Scores
Picture Completion	
Picture Arrangement	
Block Design	
Object Assembly	
Digit Symbol	

WCST.EXP

The Wisconsin Card Sorting Test is an instrument assessing cognitive flexibility by the examiner spontaneously changing "sets" and rules for card sorting without informing the subject. In this manner, one can observe how the subject responds to seemingly illogical change and what problem solving mechanisms come into play in the process of this trial and error procedure.

WCST.WNL

The patient's performances on this test were well above average and without any signs of preservation, the loss of the conceptual "set", or uninsighted random guessing that can occur when frontal systems have been compromised. This impression was further support by performances on the Porteus Maze Test, the Smith Symbol Digit Modalities Test, the Trailmaking Tests, and formal measures of controlled verbal fluency. Average or above average performances were elucidated on all of these measures which are viewed as representing functions mediated by frontal system structures.

WIAT.TAB

The Wechsler Individual Achievement Test was utilized to ascertain academic achievement levels in the areas of reading, mathematics, language, and writing. The Wechsler Individual Achievement Test (WIAT) is a comprehensive individually administered battery for assessing the achievement of children from ages 5 to 19. It consists of eight subtests whose individual items encompass a wide range of curriculum objectives. In the case of Mathematics Reasoning, for example, items assess areas related to measurement, geometry, number concepts and problem solving. Reading Comprehension items look at recognizing stated detail, recognizing stated cause and effect, sequencing, recognizing implied cause and effect, and making inferences. The Listening Comprehension and Oral Expression subtests provide information regarding the individual's receptive and expressive language skills. The Written Expression subtest assesses various writing skills including the development and organization of ideas, capitalization, and punctuation. Scores are presented as standard scores with a mean of 100 and a standard deviation of 15, with a range from 40 to 160. Grade equivalency data and percentile ranks are also available. The scores on the WIAT for _____ follow:

Subtest	Standard Score
Basic Reading	
Mathenatics Reasoning	
Spelling	
Reading Comprehension	
Numerical Operations	
Listening Comprehension	
Oral Comprehension	
Written Expression	

These individual subtest scores are then combined into composite scores. For _____ they are the following:

Reading
Mathematics
Language
Writing

WISC-III.TAB

Intellectual evaluation was conducted via the administration of the Wechsler Intelligence Scale For Children - III. This instrument provides a composite score (Full Scale IQ) which serves as an index of general intelligence as well as Verbal and Performance IQ scores. The results obtained were as follow:

Verbal IQ:
Performance IQ:
Full Scale IQ:

These scores are commensurate with functioning in the range of intelligence.

Further analysis of WISC-III performance is available via subtest analysis. The Verbal Subtests consist of tasks which tap verbal conceptual ability, practical judgment and reasoning, numerical reasoning, immediate auditory attention, acquired knowledge, and general verbal proficiency. The Performance Subtests involve more visuoperceptual and visuomotor skills in task completion. Spatial and nonverbal reasoning skills are tapped in these tasks. In addition, demands are imposed for speed dependent performance on a number of these tests. Subtests are scored as Scaled Scores with a mean of 10 and a standard deviation of 3.

Verbal Subtests	Scaled Scores
Information	
Similarities	
Arithmetic	
Vocabulary	
Comprehension	
Digit Span	

Performance Subtests	Scaled Scores
Picture Completion	
Coding	
Picture Arrangement	
Block Design	
Object Assembly	
Symbol Search	
Mazes	

WMS-R.TAB

As a formal assessment of memory the Wechsler Memory Scale-Revised (WMS-R) was utilized. The WMS-R is an individually administered, clinical instrument for appraising major dimensions of memory functions in adolescents and adults. The scale is intended as a diagnostic and screening device for use as part of a general neuropsychological examination, or any other clinical examination requiring the assessment of memory functions. The functions assessed include memory for verbal and figural stimuli, meaningful and abstract material, and delayed as well as immediate recall. There are eight subtests which comprise the scale, four of which serve as delayed-recall trials. The eight tests of short-term memory contribute to two major composite scores, General Memory and Attention/Concentration. The General Memory group is further subdivided into measures of Verbal and Visual Memory. The scaling of the WMS-R was constructed with a mean of 100 and a Standard Deviation of 15. 's scores on this formal measure of memory are as follow:

Verbal Memory
Visual Memory
General Memory
Attention/Concentration
Delayed Recall

WOODCOCK.TAB

WOODCOCK JOHNSON

	Standard Score	Percentile Rank
Word Attack		
Passage Comprehension		

WRAT-GAT

A screening of academic skills was undertaken via administration of the Wide Range Achievement Test-Revised (WRAT-R) and the Gates-MacGinitie Reading Comprehension Test. Found below are the Standard Scores and Percentiles that were derived from the WRAT-R and GATES.

WIDE RANGE ACHIEVEMENT TEST - REVISED

	Standard Score	Percentile
Reading Recognition		
Spelling		
Arithmetic		

GATES-MacGINITIE READING TEST

	Standard Score	Percentile Rank
Comprehension		

WRAT-R.TAB

A screening of academic skills was undertaken via administration of the Wide Range Achievement Test-Revised (WRAT-R). Found below are the Standard Scores and Percentiles that were derived from the WRAT-R.

	Standard Score	**Percentile**
Reading Recognition		
Spelling		
Arithmetic		

WRAT-3.KID

A screening of academic skills was undertaken via administration of the Wide Range Achievement Test - 3 (WRAT-3). Found below are the Standard Scores and Percentiles that were derived from the WRAT-3.

	Standard Score	**Percentile**	**Grade Level**
Reading Recognition			
Spelling			
Arithmetic			

WRAT-3.TAB

A screening of academic skills was undertaken via administration of the Wide Range Achievement Test - 3 (WRAT-3). Found below are the Standard Scores and Percentiles that were derived from the WRAT-3.

	Standard Score	**Percentile**
Reading Recognition		
Spelling		
Arithmetic		

Case Study

May 24, 1996

CASE STUDY

REFERRAL INFORMATION

The patient, is a 27 year old single white female residing alone in an apartment in Pittsburgh, Pennsylvania. Patient is 5'7", about 125 lbs., with dark black (possibly dyed), straight shoulder length hair, and has severe acne on her face. Patient usually presents well-groomed and casually dressed in jeans and T-shirt or blouse. Patient has a long history of psychiatric problems and substance abuse dating to adolescence, and is currently being followed by the Center for Psychiatric and Chemical Dependency (CPCDS). She has the following diagnoses as of November, 1995: Axis I: Bipolar I Disorder, depressed, severe with mood congruent psychotic features, with rapid cycling and with catatonic features; Alcohol dependence in full remission; Cannabis dependence in full remission; Obsessive Compulsive disorder by history in adolescence; Anorexia Nervosa by report in adolescence. Axis II: Personality disorder, NOS; Rule out Schizotypal and Borderline Personality disorder. Axis III: Acne. IV: Moderate stressors. V: Past GAF=30, at discharge=80. Patient was referred to the Psychiatric Rehabilitation Assessment Services Clinic (PRAS) on December 18, 1995 by D.D., MSW of CPCDS of Western Psychiatric Institute and Clinic (WPIC) for vocational consultation due to dissatisfaction with her current work situation as a word processor and desires to explore alternative choices. Initial session with C.L., B.A., was January 24, 1996. Patient is currently being followed by L.K., M.Ed., under the supervision of M.G., M.Ed., CRC.

PSYCHIATRIC HISTORY

Patient grew up in Wilkes-Barre, Pennsylvania. During her childhood, from ages ten to about fifteen, she reports obsessive thinking and compulsive rituals. These included seeing herself as bad, checking and counting, and feeling that she had to repeatedly rub germs off of her hands or bad things would happen to other people. From the ages of thirteen to seventeen, patient recalls her father calling her "fat" so she started starving herself and suffered from Anorexia Nervosa. She reports that at the age of thirteen, she was 5'4" and 130 lbs. but by the age of fourteen or fifteen, she was 5'7" and 105 lbs. Patient reports that she would lie in her bed and cry when she was a teen, thinking she might not be able to have children due to starving herself and possibly destroying her reproductive system. She still admits to some preoccupation with food and weight.

At seventeen she entered college and exchanged the anorectic behavior for alcohol abuse. Patient said that she feels alcohol saved her from getting thinner and eventually dying from Anorexia Nervosa. Patient stated she had two good friends in college and described herself as a "holy terror" and "got drunk as often as I could and I caroused in search of young men about as often as I got drunk." During her junior year of college, Patient reports that she fell in love with a man who liked to drink as much as she did, until his father got him involved in AA meetings. He in return introduced her to these meetings. In 1989, at the age of 20, patient was treated in the Dual Diagnosis Inpatient Unit at WPIC for three weeks, for severe major depression and alcoholism. After hospitalization, she participated in AA

Meetings and outpatient care in CPCDS. During her stay in the hospital she was given Prozac for depression but this was discontinued after her release due to developing mania. Prior to being treated at Braddock Mental Health Center for Bipolar Affective Disorder in 1993, patient reported multiple cycles of depression, lasting about two months, alternating with periods of euthymia and mania which lasted about two weeks. Patient described euphoria, increased energy, decreased sleep, increased sense of self-confidence and socialization, sexual promiscuity and increased drug use during her manic phases. She reported having had some thirty such cycles before being treated with Lithium at Braddock MHC and has reported no manic episodes since then. Patient reports that she stopped treatment at Braddock MHC in 1993 and received Lithium from her family doctor for the next two years.

Patient describes an experience in March of 1995 while working as a data entry temp, in which she was having a daydream or fantasy of the 1800's, during which she experienced the sensation of dying and bleeding as a result of being robbed and stabbed. She started gasping and grabbing her chest and had to leave work. In the summer of 1995, patient reported a three month episode of Major Depression manifested by depressed mood, suicidal ideation, decreased energy and concentration, sleep and appetite disturbance, poor concentration, feelings of hopelessness, and feeling detached from her body. She presented to WPIC on September 11, 1995 and was treated on an outpatient basis at the Center for Psychiatric and Chemical Dependency by D.D., MSW and I.S., M.D. Patient's depressive symptoms began to increase, including suicidal ideation to the point of thinking about preparations such as a burial plot, who would get her possessions, and what she would wear. Patient reported not committing suicide because she is not sure that things would be better in the afterlife, that she could be a ghost and would still have the same problems or would interfere with people's lives. Patient was hospitalized November 6, 1995 to November 27, 1995 at WPIC on the Women In Transition Unit and is currently in outpatient treatment at CPCDS. As was reported by her primary therapist in an April 1, 1996 progress note, patient currently takes the following medications: Risperdal 1 mg q hs po, Zoloft 25 mg q am po, and Lithium Carbonate 300 mg, 2 pills BID po.

HISTORY OF DRUG AND ALCOHOL ABUSE

In 1986, patient started drinking alcohol while in college. She reports being intoxicated up to three to four times a week, consuming large amounts of alcohol, experiencing some blackouts, missing classes, and inappropriate sexual behavior. In 1990, she reported using marijuana everyday for six months. Patient attended AA and NA in 1989 and 1990 for eight months but felt "it was too much like a cult." Patient was hospitalized in the Dual Diagnosis Inpatient Unit at WPIC for three weeks in 1989 for Severe Major Depression and Alcoholism. She reported that she has rarely drunk alcohol since she started taking Lithium and has not drunk alcohol since October of 1995. Patient said she did see herself as an alcoholic in the past, but does not see herself as one now. Patient continues with individual outpatient treatment and attends groups at CPCDS.

PERSONAL DEVELOPMENTAL AND SOCIAL HISTORY

Patient grew up in Wilkes-Barre, Pennsylvania with one younger brother. Her mother, 52 years old, stayed at home until patient was 12 years old, at which time she went to work as a prison librarian. She describes her mother as "touchy-feely," very intelligent and self-educated. Her father, 65 years old, was a high school history teacher and athletic director. He has recovered from a heart attack he had years ago. She describes her father as a "Type A" personality, "mean-willed but generous," and she feels he ordered her mother around. Patient thinks that her parents are a "strange couple" but she feels fairly close to them. Patient stated that her parents were shocked and upset to learn about her psychiatric condition. Her brother, 22 years old, attends a Masters' program at the University of Alabama. She stated that she does not feel particularly close to him. Patient said that she learned to read and write by the age of three from her mother, and was sent to kindergarten at the age of four. She described her school years as being "head and shoulders" above other classmates academically, but had a long way to go as a social success. Patient said that she did not like the town she lived in or anybody in it, thus feeling that she did not belong. As a result, she created a very active fantasy life which included many imaginary friends between the ages of three and seven. She started talking to her dolls after her mother stated she was too old for imaginary friends, and at the age of nine, patient began writing screen plays as an expression of her fantasy life. Patient related that she felt she was smothered as a child and that her parents always wanted a child who was smart and would become successful as well as be obedient and not express independence or self-assurance. Patient states that she did not have friends until she started college and drinking alcohol. She reported that her first love occurred while in her junior year of college and that this young man saved her life by introducing her to the 12-step program at AA. They are no longer together and currently she is dating a married man. Patient reports that the following people in her family have had medical or psychiatric problems: Paternal uncle has a depressive illness; paternal cousin had alcoholism and compulsive gambling disorder; Maternal great-aunt had alcoholism; Paternal aunt had cancer and a cousin is being treated with Lithium for mania.

MEDICAL HISTORY

Patient's most recent medical evaluation on November 6, 1995 at the University of Pittsburgh Medical Center reports a physically healthy adult female. She has a history of asthma with bronchitis and ovarian cysts. Patient reports an allergy to the antibiotic, Ilosone, to which as a child she reacted with anaphylaxis. Currently, she has acne which is being treated with a sulfa antibiotic medication. After patient's last hospitalization in 1995, she reported blurry vision as a result of medication (Risperdal).

SOCIAL SUPPORTS

Patient reports that she is fairly close to her parents but does not feel close to her brother. She reports improved interpersonal relationships since high school and has several close friends. Although patient grew up Catholic, she is now very active in the First Unitarian Church and choir. Music and writing are a big part of her life although she has not pursued her music career because she states that things "feel different" and she has not had the motivation to compose as of late. She is also involved in an acting class that she says helps her to relax.

CURRENT STRESSORS

Patient expresses dissatisfaction with her job as a word processor. She feels she is underemployed since she has a B.A. in liberal arts.

EDUCATION AND EMPLOYMENT

Patient was taught to read and write by her mother at the age of three and at four she began Kindergarten. In elementary school, she reports making good grades, being involved in a reading group, entering and winning awards in creative writing and learning to play the flute. In high school, she continued to get good grades and became a member of the National Honor society, the radio club, school newspaper, and many musical organizations. She received a scholarship from the teachers' association and attended college at I. University of Pennsylvania to study music education. In her final year of college she completed an internship at a public radio station in Pittsburgh, doing production work, basic audio engineering and all the technical work and editing on a weekly environmental affairs show. She graduated magna cum laude with a B.A. in liberal arts, music performance. After graduation she continued volunteering at the radio station and started working as a cashier at a supermarket. Two months later she started working as a data entry temp in Pittsburgh. During this time she was invited to play the flute in a new age music project and performed a few live shows at local pubs and bars. In 1993, she produced, engineered and performed her first recording, "Songs for Dysfunctional Girls." In 1995, she performed a few live shows and sold some tapes. After she quit her data entry temp job, around March 1995, she took six weeks off and then started her current job as a word processor with a law firm in Pittsburgh. She makes $20,000 a year, but is dissatisfied and is interested in pursuing a different career. She states that she has lost her motivation to compose music. Currently she also volunteers at a music studio and continues to write short stories. Patient stated that she feels happiest when writing her stories.

VOCATION AND PSYCHOEDUCATIONAL ASSESSMENT

Patient attended initial session at PRAS on January 24, 1996, with C.L., B.A., under the supervision of M.G., M.Ed., CRC. Reportedly, the patient was looking for a "new focus" to her career because she feels underemployed as a word processor when she has a BA. in liberal arts. Patient agreed to take the following vocational assessment measures: Career Ability Placement Survey (CAPS) administered on February 1, 1996; Career Occupational Preference System Interest Inventory, Professional level (COPS-P), Career Orientation Placement and Evaluation Survey (COPES), and Strong-Campbell Interest Inventory (SCII), administered on January 24, 1996, and the Multidimensional Self Esteem Inventory administered on May 20, 1996. Patient appeared heavily invested in vocational assessment and stated, "this makes me lean more towards going back to school because I love to keep learning." She also said she was disappointed because she expected to score better on the ability testing. To date, patient has attended fifteen sessions without missing any scheduled appointments at PRAS. Sessions have included: discussing results of vocational testing, exploration and weighing pros and cons of possible career interests, research and discussion about potential Master's degree programs, identifying goals and accomplishments and *identifying positive and negative working conditions. Currently patient has registered to take a biology class at the local community college for the summer of 1996 to explore her interest in medical-life science before committing to an educational program.*

SUMMARY AND RECOMMENDATIONS

Patient states that she is interested in exploring career opportunities because she feels underemployed working as a word processor. She has a B.A. in liberal arts with an emphasis in music performance but feels she has lost the inspiration and motivation to continue composing. Patient is very interested in challenging activities and to continue learning new things. She appears to be invested in attending therapy to learn about her symptoms and preventing relapse and attending sessions at PRAS to explore career interests. Patient seems willing to do what it takes to achieve her goals. Patient will continue to attend PRAS bimonthly for counseling and guidance toward achieving her long term goal of establishing and following through on a plan of action to aid in determining specified vocational and/or educational goals.

Recommendations include the following:

1. *Continued career guidance in an atmosphere of support and encouragement and further exploration of high interest careers.*
2. *Continued exploration of employment options while pursuing additional training/education as needed.*
3. *Further evaluation of pros and cons of working conditions and career direction.*
4. *Continued outpatient treatment focusing toward improving self-confidence and monitoring of symptoms.*
5. *Referral as needed.*

UNIVERSITY OF PITTSBURGH

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

PSYCHIATRIC REHABILITATION AND ASSESSMENT SERVICES

<VOCATIONAL CONSULTATION>

NAME: **WPIC #:** 175727 **UNIT/CLINIC:** CPCDS

REF'D BY: **DATE REF'D:** 12-18-95 **DATE RECV'D:** 12-18-95

TEST DATE(S): 1-24-96, 2-1-96, 5-20-96, 6-3-96, 6-10-96

TESTS ADMINISTERED: Wechsler Adult Intelligence Scale - Revised (WAIS-R), Wechsler Memory Scale - Revised (WMS-R), Wide Range Achievement Test - Revised (WRAT-R), Nelson-Denny Reading Test (Form F), Career Ability Placement Survey (CAPS), Career Orientation Placement and Evaluation Survey (COPES), Career Occupational Preference System Interest Inventory, Professional Level (COPS-P), Strong Campbell Interest Inventory, Minnesota Multiphasic Personality Inventory (MMPI), Multidimensional Self-Esteem Inventory (MSEI).

BACKGROUND AND REFERRAL INFORMATION:

the patient is a 27 year old single white female, referred to PRAS on 12-18-95 by of CPCDS of WPIC for vocational consultation due to dissatisfaction with her current work situation as a word processor. the patient presented to WPIC on 9-11-95 for treatment on an outpatient basis for a mood disorder. Reportedly, she has a long history of psychiatric problems dating to adolescence. From the age of 10 to 15, the patient reported obsessive thinking and compulsive rituals, which included seeing herself as bad, checking and counting and feeling she had to repeatedly rub germs off of her hands or bad things would happen to other people. During the ages of 13 to 17, she reported starving herself and developed anorexia nervosa with a 25 lb. weight loss. the patient stated that her anorectic behavior ceased when she entered college and started abusing alcohol. In 1989, at the age of 20, the patient attended AA meetings with the help of her then, current boyfriend and in 1989, entered the Dual Diagnosis Inpatient Unit at WPIC for treatment of alcoholism and was also treated with Prozac for severe Major Depression. Prior to being treated at Braddock MHC for Manic Depressive Illness in 1993, the patient reported multiple cycles of depression, lasting about two weeks. During her manic phases, the patient described euphoria, increased energy, decreased sleep, increased alcohol and marijuana use. the patient stopped treatment with Braddock MHC in 1993 and received Lithium from her family doctor until 1995. As the patient became more depressed, suicidal, and experiencing periods of dissociation, she entered the Women in Transition Unit of WPIC from November 6, 1995 to November 27, 1995. Currently, the patient is followed by of CPCDS at WPIC and takes Lithium Carbonate, 300 mg. and Zoloft 25 mg. daily.

Medically, the patient is a physically healthy adult female as reported by medical evaluation on 11-6-95. She has a history of asthma with bronchitis and ovarian cysts and currently is being treated with a sulfa antibiotic medication for acne. She wears contact lenses for corrective vision.

Educationally, the patient reported that her mother taught her to read and write by the age of 3 and she entered kindergarten at age four in Wilkes-Barre, PA. Through high school, the patient stated making A's and B's and being involved with music and creative writing groups. She received a scholarship from the teachers' association and majored in music education at Indiana University of PA. She graduated in 1990, magna cum laude with a B.A. in liberal arts, music performance. Currently, the patient has registered to take classes this summer to further explore her interest in Medial-Life Science.

the patient has been employed as a cashier at a supermarket, a data temp and currently works as a word processor with a lawyer's firm making $20,000 per year. As an intern in college she worked at a local radio station doing production work, basic audio engineering and all the technical work and editing on a weekly environmental affairs show. In 1993, she played the flute in a new age music project and performed a few live shows at local pubs and bars, and produced, engineered and performed her first recording, "Songs for Dysfunctional Girls." In 1995 she performed a few live shows and sold some tapes. Currently, the patient states that she has lost her motivation to compose music but has started writing short stories in her spare time.

OBSERVATIONS OF TEST BEHAVIOR:

Formal vocational assessment was conducted on 1-24-96, 2-1-96, 5-20-96, 6-3-96, and 6-10-96. the patient expresses excitement and stated she likes challenges and taking tests, and appeared very invested in vocational and psychoeducational assessment. the patient appeared noticeably anxious and self-conscious during the beginning of the WMS-R and WAIS-R, thus possibly hindering her performance, which improved as she calmed down. During interpretation of results, the patient felt she should have scored higher on the CAPS but quickly stated she had more reason than ever to go back to school and "stimulate" her mind again. the patient always appeared attentive and was an eager participant when engaging in vocational sessions. Keeping in mind her test anxiety, results appear to be a valid representation of the patient's current abilities.

TEST RESULTS AND DISCUSSION:

Intellectual evaluation was conducted via the administration of the Wechsler Adult Intelligence Scale - Revised. This instrument provides a composite score (Full Scale IQ) which serves as an index of general intelligence as well as Verbal and Performance IQ scores. The results obtained were as follows:

Verbal IQ:	123
Performance IQ:	113
Full Scale IQ:	122

the patient's full scale score places her in the superior range of intelligence. While superior verbal skills are conveyed, performance placed in the high average range of abilities.

Further analysis of WAIS-R performance is available via subtest analysis. The Verbal Subtests consist of tasks which tap verbal conceptual ability, practical judgment and reasoning, numerical reasoning, immediate auditory attention, acquired knowledge, and general verbal proficiency. The Performance Subtests involve more visuoperceptual and visuomotor skills in task completion. Spatial and nonverbal reasoning skills are tapped in these tasks. In addition, demands are imposed for speed dependent performance on a number of these tests. Subtests are scored as Scaled Scores with a mean of 10 and a standard deviation of 3.

Verbal Subtests	Scaled Scores	Performance Subtests	Scaled Scores
Information	14	Picture Completion	10
Digit Span	14	Picture Arrangement	13
Vocabulary	15	Block Design	12
Arithmetic	11	Object Assembly	10
Comprehension	16	Digit Symbol	14
Similarities	12		

Verbally, the patient has a very superior ability to utilize practical information and social judgment in everyday problem solving (Comprehension). The ability to demonstrate an adequate fund of general and factual knowledge, closely tied to academic success, is in the superior range (Vocabulary), as is attention, concentration and immediate auditory recall of number series (Digit Span). High average ability in logical abstract thinking and verbal concept formation was evident (Similarities). An average score was obtained on Arithmetic, which requires sustained attention to aural direction and the ability to mentally manipulate and solve arithmetic procedures.

Nonverbally, a superior score was recorded on Digit Symbol which measures visual-motor coordination and psychomotor speed in associating unfamiliar symbols with familiar numbers requiring speed, attention and concentration. High Average scores were obtained on Picture Arrangement, measuring the ability to use logical planning, anticipation and social insight to comprehend and interpret social situations, and Block Design, which requires attention, concentration, nonverbal reasoning and spatial-problem solving abilities. Average scores were recorded on Picture Completion, which requires visual alertness, perception and attention in discriminating between essential and unessential details, and Object Assembly, which requires the ability to visually identify and organize parts into meaningful wholes under speed requirements.

Bannatyne recategorization of WAIS-R scores looks at three cognitive factors which have been linked with and are utilized in the processing of information and learning and a fourth factor labeled, Acquired Knowledge. The three primary factors consist of spatial, conceptual, and sequential ability areas, each of which is summarized by way of a mean rating. The spatial category is based upon the Block Design, Object Assembly, and Picture Completion subtests; the Conceptual category is based upon the Vocabulary, Similarities, and Comprehension subtests; and the sequential category is comprised of the Digit Span, Digit Symbol, and Arithmetic subtests. The final category, Acquired Knowledge is based upon the Information, Arithmetic, and Vocabulary subtests and thus generally reflects the impact of formal academic experiences. the patient's Bannatyne recategorized scores result in the following profile:

Conceptual	>	Sequential	>	Spatial	Acquired Knowledge
M = 17.6		M = 13.0		M = 10.6	M = 13.3

the patient's results indicate very superior conceptual abilities, high average sequential abilities and average spatial abilities; resultant acquired knowledge score is in the high average range.

As a formal assessment of memory the Wechsler Memory Scale-Revised (WMS-R) was utilized. The WMS-R is an individually administered, clinical instrument for appraising major dimensions of memory functions in adolescents and adults. The scale is intended as a diagnostic and screening device for use as part of a general neuropsychological examination, or any other clinical examination requiring the assessment of memory functions. The functions assessed include memory for verbal and figural stimuli, meaningful and abstract material, and delayed as well as immediate recall. There are eight subtests which comprise the scale, four of which serve as delayed-recall trials. The eight tests of short-term memory contribute to two major composite scores, General Memory and Attention/Concentration. The General Memory group is further subdivided into measures of Verbal and Visual Memory.

The scaling of the WMS-R was constructed with a mean of 100 and a Standard Deviation of 15. the patient's scores on this formal measure of memory are as follow:

	Standard Score	**Range**
Verbal Memory	100	Average
Visual Memory	95	Average
General Memory	97	Average
Attention/Concentration	122	Superior
Delayed Recall	97	Average

the patient demonstrated superior abilities of attention and concentration, average memory for verbal and visual information and average delayed recall. Anxiety appeared to hinder her initial encoding of the verbally presented material (two short stories read aloud), thus lowering both her verbal and general memory scores. Additionally, she appears to experience memory problems due to depression.

A screening of academic skills was undertaken via administration of the Wide Range Achievement Test-Revised (WRAT-R). Found below are the Standard Scores and Percentiles that were derived from the WRAT-R.

	Standard Score	**Percentile**	**Range**
Reading Recognition	118	88	High Average
Spelling	124	95	Superior
Arithmetic	108	70	Average
Untimed Arithmetic	125	95	Superior

the patient performed extremely well on the spelling subtest, missing only two out of 46 items. Basic phonetic skills are within a high average range. Under time constraints, she demonstrated average ability in arithmetic, but given the opportunity to complete the remaining problems without constraints, she scored in the superior range, demonstrating her facility in basic Algebra. It is important to note that the patient has recently been reviewing arithmetic in preparation for an algebra class which she has registered to take in the fall semester.

Nelson-Denny Reading Test (Form F)

	Standard Score	Percentile Rank	Range
Reading Comprehension	112	79	High Average
Reading Rate	77	08	Borderline

the patient demonstrated high average ability in reading comprehension. It is felt that her score of borderline on reading rate is an underestimation given the fact that she completed the test before allotted time elapsed and that initial anxiety and awareness of being "tested" appeared to impair her initial performance.

On the CAPS, a measure of eight primary ability areas associated with the Occupational Clusters presented in the CCOPS vocational aptitude and interest battery, the following aptitude scores were derived:

	Primary Ability	Stanine Score	Percentile Score	Range
MR	Mechanical Reasoning	2	8	Deficient
SR	Spatial Relations	6	68	Average
VR	Verbal Reasoning	6	68	Average
NA	Numerical Ability	4	32	Average
LU	Language Usage	9	98	Very Superior
WK	Word Knowledge	5	50	Average
PSA	Perceptual Speed and Accuracy	5	50	Average
MSD	Manual Speed and Dexterity	6	68	Average

the patient's score on language usage demonstrates very superior abilities in recognizing and using standard English grammar and punctuation. Average scores were obtained across all other CAPS subtests except for a score in the deficient range on understanding of mechanical facts and principles. An average score on the subtest measuring abstract verbal reasoning ability is inconsistent with superior verbal comprehension abilities demonstrated on the WAIS-R. The lower CAPS subtest score appears due to test anxiety and time constraints vs. true ability in this area.

Enclosed with this report is a print-out of scores including Percentile Scores and those Occupational Clusters within which scores are high enough to consider them as potential areas for career exploration, dependent of course on expressed vocational interests and work values.

The Career Orientation Placement and Evaluation Survey (COPES) was administered in order to assess those personal values which have been repeatedly demonstrated to reflect major dimensions of job satisfaction. In conjunction with interests, what one would "like" to do, those domains which one values or perceives as important and worthwhile play an important role in career choice and job satisfaction. Work values measured by the COPES are described below.

INVESTIGATIVE vs. ACCEPTING: Intellectual curiosity and the challenge of solving a complex task are major values of persons scoring high on this scale. The need for information is very important to such people. Low scorers value clear cut activities in which they see the concrete results of their work and do not need to solve many complex problems.

PRACTICAL vs. CAREFREE: Showing proper appreciation for one's personal belongings and appreciation of practical and efficient ways of doing things are major values of persons scoring high on this scale. Such persons value activities in which they take good care of their property and work with things to make them more practical and efficient. Low scorers value activities where others take care of equipment and keep things in good working order.

INDEPENDENCE vs. CONFORMITY: Independence from rules, regulations, and social conventions, and the freedom to work on their own are major values of persons scoring high on this scale. Such persons value activities in which they are relatively free of rules and regulations and are not restricted by social obligations. Low scorers value working under careful supervision where clear directions and regulations can be followed.

LEADERSHIP vs. SUPPORTIVE: Making decisions, directing others, and speaking for the group are major values of persons scoring high on this scale. Such persons have a need to be seen as important and usually take positions of leadership. Low scorers value activities in which they can be a good follower and do not need to direct others or tell others what to do.

ORDERLINESS vs. NON-COMPULSIVE: Orderliness and keeping things neat and in their proper place are major values of persons scoring high. Such persons value activities in which they keep things tidy and do what they are expected to do. Low scorers value activities in which they can take things as they come and do not need to keep things orderly.

RECOGNITION vs. PRIVACY: To become well known and famous and to know important people are major values of persons scoring high on this scale. Such persons seek the admiration of others, as well as the rewards of honorary degree. Low scorers value keeping their activities private and are not concerned with being considered a famous person.

AESTHETIC vs. REALISTIC: Artistic appreciation and the enjoyment of music and the arts are major values of persons scoring high on this scale. Such persons value activities in which they appreciate beauty, show artistic and emotional sensitivity, and appreciate music and the arts. Low scorers value activities in which they do not rely on their senses and in which they are not involved with appreciation of artistic qualities.

SOCIAL vs. SELF-CONCERN: Helping others and appreciating the work of charitable service groups are major values of persons scoring high on this scale. Working with people in a friendly situation is important to such persons. Low scorers value activities in which they spend time on their own projects and tend to their own affairs rather than helping others.

Work and/or activity which incorporates value preferences is seen to be intrinsically worthwhile and indicative of job satisfaction for the majority of individuals. The work related values which are most important to the patient are listed below; preference for the underlined work value is indicated by percentile rank.

Work Value Scale	Percentile Rank	Range
Investigative vs. Accepting	97	Very Strong
Practical vs. Carefree	10	Very Low
Independence vs. Conformity	99	Very Strong
Leadership vs. supportive	80	Strong
Orderliness vs. Non-Compulsive	05	Very Low
Recognition vs. Privacy	98	Very Strong
Aesthetic vs. Realistic	98	Very Strong
Social vs. Self-Concern	05	Very Low

the patient's profile indicates that she very strongly prefers work which is intellectually challenging and complex, allows for independence from rules and regulations, and the freedom to work on her own without social obligations. She would very much like to have her accomplishments be admired, honored and recognized by others. She strongly prefers work that is involved with appreciation of beauty, music and the arts. Also indicated is a dislike for work which involves being practical, efficient, orderly, and having to work closely with others as part of a team.

The COPS-P is a self-report measure which allows the individual to select and more carefully define the kind of work which he/she may be interested in doing. Choices are given regarding a variety of activities which are performed and/or are a part of many and diverse occupations. The individual is asked to make choices based on personal interests rather than on consideration of factors such as salary, social standing, or future advancement. These many activities are then categorized with respect to the sixteen professional-level occupational clusters detailed in the CCOPSystem and reported as percentile ranks. the patient's highest reported vocational interest areas fall under the career clusters of:

	Percentile
1. Written Communication	91
2. Performing Arts	86
3. Medical-life Science	83
4. Civil Technology	75
5. Agribusiness (Outdoor)	75

COMMUNICATION, Written occupations involve activities concerned with skill in the use of written language especially in the creation or interpretation of literature and the written communication of knowledge and ideas. Sample occupations include Copy Writer, Editorial Assistant, Librarian, Technical Writer, Editor, and Reporter.

ARTS, Performing occupations involve activities concerned with the individualized expression of creative or musical talent. Sample occupations include Musician, Choreographer, Dancer, and Actress.

SCIENCE, Medical- Life occupations involve activities concerned with the conducting of research and the accumulation and application of systemized knowledge in medicine and the biological and life sciences. Sample occupations include Anesthesiologist, Pharmacologist, Physiatrist, Geneticist, and Biomedical Engineer.

TECHNOLOGY, Civil-Construction occupations involve activities concerned with the structural design for construction of buildings, highways and other transportation systems. Sample occupations include Structural Drafter, Mining Engineer and Safety Engineer.

OUTDOOR, Agribusiness occupations involve activities performed primarily out-of-doors which are concerned with the growing, tending and harvesting of plants and animals for human consumption. Sample occupations include Dairy Technologist, Farmer, Horticulturist, Soil Conservationist, and Range Manager.

the patient's profile clearly indicates Written Communication as a high interest and she has stated that she feels her best when writing short stories. Her interest in Performing Arts was manifested as a flute player in a new age program and her work and performance on a recording, "Songs for Dysfunctional Girls." the patient has started to pursue her interest in Medical-life Science through taking classes in Biology and Chemistry.

A second measure of occupational interest was utilized to further explore the patient's career interests. The Strong-Campbell Interest Inventory (SCII) yields systematic information about patterns in one's vocational interests and how these patterns compare with those of successful people in many occupations. Results are based on interests, not aptitudes or abilities. Indicated likes and dislikes are analyzed in three main ways: 1) "General Occupational Themes" for similarity to six important overall patterns; 2) "Basic Interest Scales", for similarity to 23 clusters of specific activities; and 3) "Occupational Scales", for similarity to the interests of men and woman successfully employed in 106 occupations.

Found below is the patient's profile on the General Occupational Themes of the SCII. The range of scores is roughly from 30 to 70, with the average person scoring 50.

GENERAL OCCUPATIONAL THEME	SCORE	RANGE
Realistic	39	Moderately Low
Investigative	43	Average
Artistic	60	Moderately High
Social	44	Average
Enterprising	41	Moderately Low
Conventional	35	Low

Of the 23 Basic Interest Scales of the SCII, the patient's interest reached average or higher on the following scales:

BASIC INTEREST SCALE	SCORE	RANGE
Medical Science	57	Moderately High

the patient's responses were very similar or similar to those of persons working in occupations corresponding to 9 of the 106 Occupational Scales of the SCII.

Broadcaster	Very Similar
Reporter	Moderately Similar
Florist	Moderately Similar
Interior Decorator	Moderately Similar
Librarian	Moderately Similar
Artist, fine or commercial	Similar
Photographer	Similar
Musician	Similar
Advertising Executive	Similar

There are two Special Scales on the SCII designed to yield additional insight into interests and expectations. The Academic Comfort Scale differentiates between people who enjoy being in an academic setting and those who do not. Persons with low scores (below 40) often are inclined to view education as a necessary hurdle for entry into a career, whereas persons with high scores (above 50) typically seek out academic courses. the patient's score of 48 on this scale indicated a moderate inclination toward formal academic coursework. The Introversion-Extroversion Scale is associated with a preference for working with things or ideas (scores above 55) or with people (scores below 45). the patient's score of 49 on this scale indicates a preference for working with things, ideas and people.

Enclosed with this report is the patient's comprehensive SCII Profile Report and further interpretive information.

Assessment of self-esteem and personality was conducted via use of the MSEI and the MMPI.

Results of the MSEI indicate moderate difficulties in feeling lovable and accepted as a person as well as confusion around her sense of identity and purpose in life. Such persons may have difficulty expressing or receiving feelings of love and experience much inner conflict among different aspects of self-concept. Also present is some confusion and guilt with regard to moral values and behavior. the patient attributed these feelings of guilt to growing up as a strict Catholic and currently attending a very liberal Unitarian Church. the patient's profile also indicated feelings of competence and capability in mastering new tasks and learning quickly, feeling talented and capable of doing well at most things.

the patient's MMPI profile was indicative of an individual currently experiencing a significant amount of emotional distress. Persons with similar profiles typically are obsessive, worrisome, oversensitive individuals who are apt to present with complaints of anxiety, nervousness, tension and depression. They are apt to show marked psychic distress and to complain of difficulty in thinking and concentration. They are apt to be indecisive and passive in their relationships with others and indulge in a rich fantasy life and daydreaming. These persons may suffer from depersonalization, delusions and hallucinations.

Additionally, persons with a similar profile tend to be isolated, aloof and although desire some contact with others, most often want to avoid contact that they cannot cope with comfortably and often experience social anxiety. They may have recurrent illusions, ideas of reference, and engage in magical thinking, which seem to be coping mechanisms to fill their inner void. They feel disembodied and often have dissociative experiences. Often they are detached, uninvolved observers of the world and others with behavior and appearance often considered odd or eccentric. When social demands and expectations press upon them, they feel an excess of environmental stimulation and often react by dissociating, or with paranoia and delusional thoughts.

SUMMARY AND RECOMMENDATIONS:

the patient underwent formal vocational and psychoeducational assessment on 1-24-96, 2-1-96, 5-20-96, 6-3-96, and 6-10-96. Assessment results indicate overall cognitive functioning in the Superior range of abilities. Verbal comprehension abilities are in the Superior range and perceptual organizational abilities are in the High Average range. Weaknesses in measured vocational aptitudes do not reflect abilities demonstrated in intellectual functioning, and appear to be due to test anxiety and time constraints. Attention and concentration abilities are in the superior range; verbal, general and delayed memory functions are in the average range and appear to be related to symptoms of depression. Basic academic skills are above average and are commensurate with measured verbal and overall cognitive functioning.

Vocational interests reflect the patient's history of musical performance and current interest in writing. Although she had not considered Medical-life science as a career, she is currently exploring this possibility with a class in biology and has registered for chemistry, biology II, and algebra for the fall at Community College of Allegheny County. the patient has decided to remain working at her $20,000 a year job as a word processor while she explores vocational interests. While scores indicate that the patient has the intelligence and capabilities to succeed at the career of her choice, her MMPI profile reflects emotional distress that could interfere with this success.

Recommendations:

1. Continued outpatient therapy and treatment.
2. Continued career counseling and guidance on an as needed basis.

Date: August 8, 1996

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

Patient Name: [redacted] Hospital No.: [redacted] Program: PRAS

DATE	PROB NO	PROBLEMS	GOALS AND MEASURABLE PERFORMANCES	METHODS	TARGET DATE	ATTAIN DATE
7/5/86	E1	JE is currently underemployed and dissatisfied with her work situation; desires to explore alternatives including furthering her education.	Long Term Goal: JE has established and followed through on a plan of action to aid in determining specified vocational and/or educational goals. Short Term Goals: 1. JE will review previous educational and vocational experiences to aid in current planning. 2. JE will complete a vocational assessment battery and utilize results in career exploration. 3. JE will explore areas of high interest career alternatives/educational options. 4. JE will investigate employment options while exploring educational opportunities. 5. JE will identify pros and cons of potential career direction. 6. JE will report an increased sense of self confidence.	PRAS clinicians, C L , B.A., and M C . M.Ed., CRC, will provide on an as needed, individual basis: - administration of vocational battery and review of results - career guidance and exploration - referral and liaison services as indicated		

This written document does not constitute a legal contract guaranteeing or promising treatment outcomes.

[redacted]

Field	Pros	Cons
1. Word-oriented jobs -- linguistics, translator, technical writer, communications	Talented with words Enjoy writing and language Will probably "fit in" as a person with others in this discipline	Difficulty finding work Ex.: What do you do with a linguistics degree?
2. Psychology	Interested in the mind and how it works Have had a strong aptitude for psychology in past course work	Don't really believe in most counseling Would be most interested in reasarch - need Ph.D. - not as many jobs
3. Physical Therapy	Enjoy active-type work Enjoy helping people/being a healer	Seeing handicapped patients every day may disturb me and/or make me sad Heavy science requirements in school
4. Chiropractor	Interested in healing Interested in the human body Interested in things that are "alternative" Run own business or practice with group	The public and other medical professionals often have poor opinion of profession Not sure if I believe in the ideology 100% Almost as much schooling required as to be a traditional physician Heavy science requirements
5. Traditional Physician	Interested in healing Interested in the human body Respected member of community Run own business or practice with group	Heavy science requirements Lots of schooling Near-spotless academic record Expensive, long-term commitment

Field	Pros	Cons
6. Staying Where I Am (i.e., music with odd jobs or vice versa)	Jobs are easy for me and leave me with free time and a reliable paycheck No school debt My musical project has been the most meaningful and satisfying work I've ever done	Right now is not a particularly creative time in my life, due to various circumstances Jobs are mind-numbing, dull, unchallenging Struggle to find respect, always feel I have to explain myself/my lot in life Put out much more than I've gained from musical project in the way of sacrifices

General Concerns

1. How do I know this isn't just a "phase"? (wanting to go back to school, wanting to change careers, etc.) How badly do I want any of the above careers, and is it realistic to try to obtain them?

2. Can I do it? Will I actually, if given the chance, go back to school and apply myself in previously scoffed-at subjects?

3. Where is the money going to come from? Can I work full-time and still go to several classes a week? Or can I work part-time and live on that income?

4. Will what I do make that much difference in my happiness, or am I asking for trouble by asking for more job responsibility and giving up on the career I used to want more than anything?

TEST SCORES

Career Ability Placement Survey

	Stanine Score
1MR Mechanical Reasoning	*2*
2SR Spatial Relations	*6*
3VR Verbal Reasoning	*6*
4NA Numerical Ability	*4*
5LU Language Usage	*9*
6WK Word Knowledge	*5*
7PSA Perceptual Speed and Accuracy	*5*
8MSD Manual Speed and Dexterity	*6*

COPES

	Percentile
Investigative vs Accepting	*97*
Practical vs Carefree	*10*
Independence vs Conformity	*98*
Leadership vs Supportive	*80*
Orderliness vs Non-Compliance	*5*
Recognition vs Privacy	*98*
Aesthetic vs Realistic	*98*
Social vs Self-Concern	*5*

COPS-P

Highest interest level in following three areas:

Communication (written) 91%
Arts (performing) 88%
Science (medical-life) 83%

STRONG-CAMPBELL INTEREST INVENTORY (SCII)

General Occupational Themes	Score	Range
Realistic	*39*	*Moderately low*
Investigative	*43*	*Average*
Artistic	*60*	*Moderately high*
Social	*44*	*Average*
Enterprising	*41*	*Moderately low*
Conventional	*35*	*low*

Basic Interest Scales	Score	Range
R-Adventure	*51*	*Average*
I-Medical Science	*57*	*Moderately high*
I-Medical Service	*48*	*Average*
A-Music/Dramatics	*56*	*Average*
A-Art	*57*	*Average*
A-Writing	*56*	*Average*
S-Social Service	*45*	*Average*
S-Domestic Arts	*49*	*Average*
S-Religious Activities	*53*	*Average*
E-Public Speaking	*54*	*Average*
E-Merchandising	*54*	*Average*
E-Sales	*53*	*Average*

Occupational Scales

Broadcaster	*very similar*
Reporter	*mod. similar*
Florist	*mod. similar*
Interior decorator	*mod. similar*
Librarian	*mod. similar*
Artist, fine or commercial	*similar*
Photographer	*similar*
Musician	*similar*
Advertising executive	*similar*

Academic Comfort scale: *48*
Introversion-Extroversion: *49*

Multidimensional Self Esteem Inventory

SCALE	*T-SCORE*	*RATING*
Global Self-Esteem (GSE)	*27*	*Average*
Competence (CMP)	*43*	*Mod. High*
Lovability (LVE)	*26*	*Mod. Low*
Likability (LKE)	*31*	*Average*
Personal Power (PWR)	*34*	*Average*
Self-control (SFC)	*30*	*Average*
Moral Self-approval (MOR)	*33*	*Average*
Body Appearance (BAP)	*33*	*Average*
Body Functioning (BFN)	*29*	*Average*
Identity Integration (IDN)	*21*	*Mod. Low*
Defensive Self-enhancement (DEF)	*52*	*Average*

MSEI Profile Form / Females

Name [redacted]
Age 27
Date 5/20/96

Percentile	T Score	GSE	CMP	LVE	LKE	SFC	PWR	MOR	BAP	BFN	IDN	DEF	T Score	Percentile
99.9	80	50	50	50	50	49	48	50	49	50	48		80	99.9
99.8	79	48-49		49	49				46-48	48-49			79	99.8
99.7	78												78	99.7
99.6	77		49		48						47		77	99.6
99.5	76					48	47						76	99.5
99.4	75									47			75	99.4
99.2	74	47			47	47	46			46	46		74	99.2
98.9	73		47-48				45			45			73	98.9
98.6	72					46			45				72	98.6
98.2	71	46	46	48	46		44		44			64	71	98.2
97.7	70					45			43	44	45	62-63	70	97.7
97.1	69	45			45				42		44	61	69	97.1
96.4	68		45	47		44	43	49				60	68	96.4
95.5	67	44			44					43	43	59	67	95.5
94.5	66					43	42	48	41				66	94.5
93.3	65	43	44		43				40	42		58	65	93.3
91.9	64	42	43	46		42		47			42		64	91.9
90.3	63	41			42		41		39	41	41	57	63	90.3
88.5	62	40	42	45	41	41	40	46				56	62	88.5
86.4	61		41			40			38	40	40		61	86.4
84.1	60			44	40		39	45	37			55	60	84.1
81.6	59	39	40							39		54	59	81.6
78.8	58	38		43	39	39	38	44		38	39		58	78.8
75.8	57					38		43	36	37	38	53	57	75.8
72.6	56	37	39	42			37			36	37	52	56	72.6
69.1	55	36		41	38			42	35			51	55	69.1
65.5	54		38			37	36		34	35	36	50	54	65.5
61.8	53	35		40	37			41	33	34			53	61.8
57.9	52	34	37	39		36	35			33	35	49	52	57.9
54.0	51			38		35	34	40	32		34	48	51	54.0
50.0	50	33	36	37	36		33		31	32		47	50	50.0
46.0	49	32	35		35	34	32	39	30	31	33	46	49	46.0
42.0	48	31		36	34	33				30	32	45	48	42.0
38.2	47	30	34	35		32	31	38	29		31		47	38.2
34.5	46	29		34	33		30			29	30	44	46	34.5
30.9	45		33	33	32	31	29	37	28	28	29	43	45	30.9
27.4	44	28		32		30		36	27		28	42	44	27.4
24.2	43	27	32	31		29	28		26	27	27	41	43	24.2
21.2	42	26	31	30	31	28	27	35	25	26		40	42	21.2
18.4	41	25	30					34	24	25	26	39	41	18.4
15.9	40	24		29	30	27	26	33	23				40	15.9
13.6	39		29	28					22	24	25	38	39	13.6
11.5	38	23	28		29	26	25	32		23	23-24		38	11.5
9.7	37	22	27	27	28	25		31	21		22	37	37	9.7
8.1	36		26	25-26		24	24	30	20	22	21	36	36	8.1
6.7	35	21	25	24	27		23			21		35	35	6.7
5.5	34		24	23		23		29	19		20	34	34	5.5
4.5	33	20	23				22	28	18	20	19	33	33	4.5
3.6	32	19	22	21-22	26	22	21	26-27		19	18	32	32	3.6
2.9	31	18	21		25	21	20	25	17		17		31	2.9
2.3	30		20	19-20		20		24		18	16	31	30	2.3
1.8	29		19	18	24		19	23	16				29	1.8
1.4	28	17			23	19		21-22	15	17		29-30	28	1.4
1.1	27	15-16		17	22	18	18	20	14		15	28	27	1.1
0.8	26	14		15-16		17		19	12-13		14	26-27	26	0.8
0.6	25	13											25	0.6
0.5	24					16	17	15-18		13-16			24	0.5
0.4	23												23	0.4
0.3	22											25	22	0.3
0.2	21		17-18		18-21		16	11-14	11	11-12	11-13		21	0.2
0.1	20												20	0.1

Sig High

Mod High

avg.

Mod low

Sig. low

Scoring Grid

	[illegible] GSE1	11 CMP1	[illegible] LVE1	2 LKE1	[illegible] SFC1	[illegible] PWR1	21 MOR1	18 BAP1	[illegible] BFN1	2 IDN1	17 DEF1
	[illegible] GSE2	[illegible] CMP2	[illegible] LVE2	[illegible] LKE2	[illegible] SFC2	20 PWR2	12 MOR2	15 BAP2	10 BFN2	3 IDN2	[illegible] DEF2
									9 BFN3	4 IDN3	[illegible] DEF3
Total Raw Score	27 GSE	[illegible] CMP	[illegible] LVE	31 LKE	[illegible] SFC	[illegible] PWR	[illegible] MOR	[illegible] BAP	[illegible] BFN	21 IDN	52 DEF

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The Multidimensional Self-Esteem Inventory

Table 2
Characteristics of High and Low Scorers

Scale	High Scores	Low Scores
A. Global Self-esteem (GSE)	Pleased with self, feels significant as a person, self-confident, pleased with past, expects future successes.	Self-critical, dissatisfied with self, feels insignificant as a person, self-doubting, displeased with past, expects future failures unless major life changes are made.
B. Components of Self-esteem		
1. **Competence (CMP)**	Competent, feels capable of mastering new tasks, learns quickly and does well at most things, feels talented, feels effective and capable.	Incompetent, feels unable to master new tasks, learns slowly and often fails in difficult endeavors, ineffective, feels lacking in skills or talents.
2. **Lovability (LVE)**	Worthy of love, feels cared for by loved ones, accepted as a person, can count on support from loved ones, able to express and receive feelings of love, involved in satisfying intimate relationship.	Unlovable, doubts that loved ones care, fears rejection because of certain aspects of personality, unsure whether loved ones can be counted on for support, has difficulty expressing or receiving feelings of love, doubts about finding or maintaining an intimate relationship.
3. **Likability (LKE)**	Likable, popular, accepted by peers and included in their plans, enjoyable companion, gets along well with others, popular in dating situations, expects to be liked, makes a good first impression.	Unlikable, unpopular, not accepted by peers and often excluded from peers' plans, has difficulty enjoying being with and getting along with others, unsuccessful in dating situations, fears rejection, and often makes a poor first impression.
4. **Personal Power (PWR)**	Powerful, successfully seeks positions of leadership, good at influencing others' opinions and behaviors, assertive, has a strong impact on others.	Powerless, poor leader and avoids leadership positions, a follower who is strongly influenced by others' opinions and behaviors, unassertive, rarely has a strong impact on others.
5. **Self-control (SFC)**	Self-disciplined, persevering, good at setting and achieving goals, not easily distracted, in control of emotions, exercises restraint in eating, drinking, and/or use of drugs.	Lacks self-discipline, often fails to complete tasks, difficulty with setting and achieving goals, easily distracted, not in control of emotions, lacks self-control in eating, drinking, or use of drugs.
6. **Moral Self-approval (MOR)**	Pleased with moral values and behavior, has clearly defined moral standards and acts in a way that is consistent with moral values, sets a positive moral example for others.	Guilty and displeased with moral values or behavior, unclear about moral beliefs and standards, often acts in an unethical or immoral manner, ashamed of setting a poor moral example for others.
7. **Body Appearance (BAP)**	Physically attractive, pleased with appearance, feels that others are attracted because of appearance, feels sexually attractive, takes care to enhance physical appearance.	Physically unattractive, displeased with appearance, feels that others are repelled by their looks, doubts sexual attractiveness, indifferent or unaware of ways to improve physical appearance.
8. **Body Functioning (BFN)**	Well-coordinated, agile, in good physical condition, comfortable with body, enjoys physical activities such as dancing or sports, feels healthy and feels a sense of vitality and vigor in body functioning.	Awkward, clumsy, uncoordinated, in poor physical condition, uncomfortable with body, dislikes engaging in physical activities, feels unhealthy and that body is dull, lifeless, and sluggish.
C. Identity Integration (IDN)	Clear sense of identity, knows who he/she is, knows what he/she wants out of life, well defined long-term goals, inner sense of cohesion and integration of different aspects of self-concept.	Confused, lacking a sense of identity and purpose, unsure of what he/she wants out of life, no long-term goals, much inner conflict among different aspects of self-concept.
D. Defensive Self-enhancement (DEF)	Defensive, overly inflated view of self-worth, claims to possess highly unlikely positive qualities, denies ubiquitous human weaknesses.	Open, nondefensive evaluation of self-worth, makes no claims of rare virtues, and acknowledges common human weaknesses.

70 & ↑ Significantly High
60-69 Moderately High
40-59 Average
30-39 Moderately Low
29 & ↓ Significanty Low

1662

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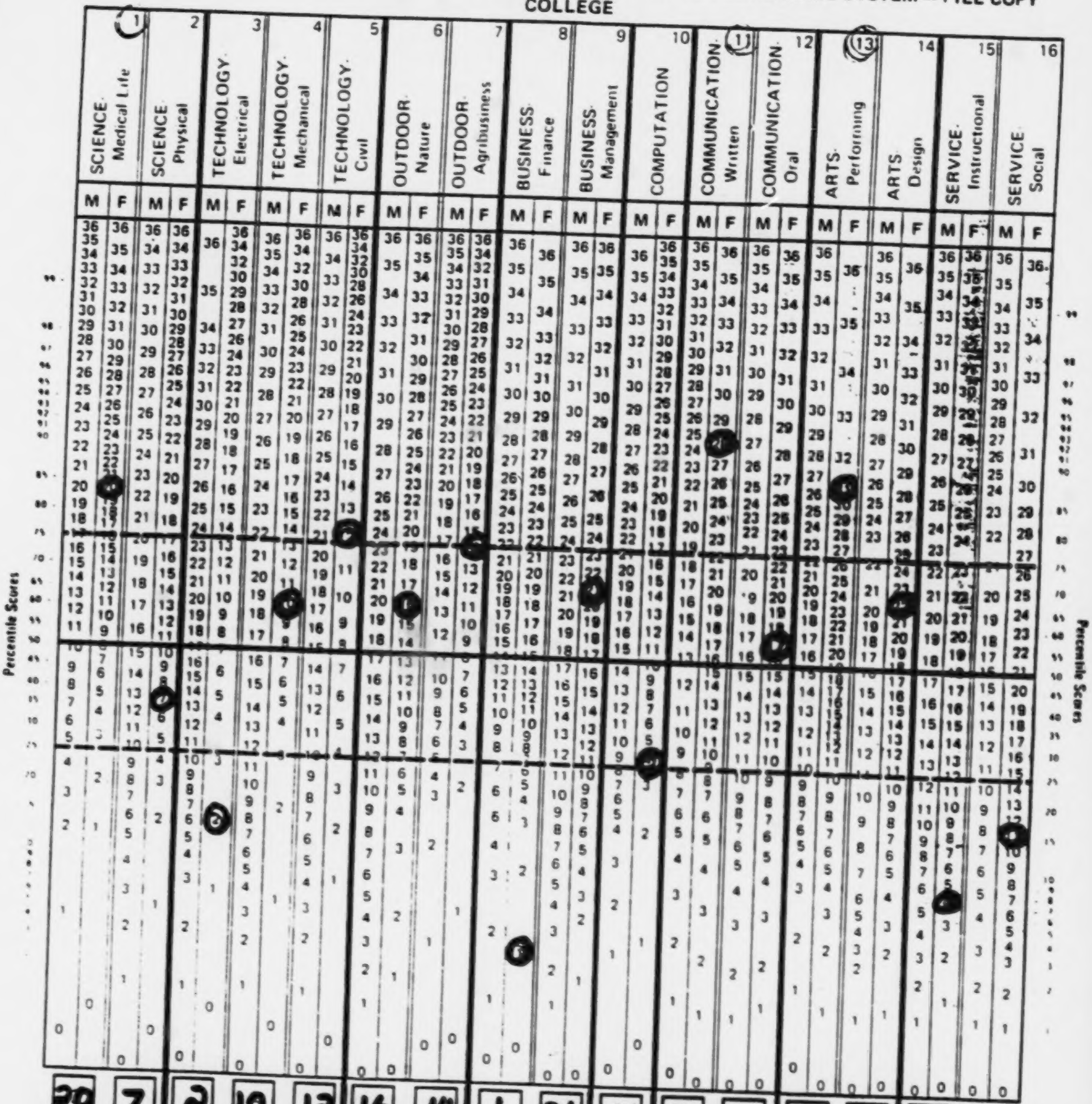
SUMMARY PROFILE SHEET FOR THE COPS-P CAREER OCCUPATIONAL PREFERENCE SYSTEM — FILE COPY
COLLEGE



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
20	7	2	10	12	16	14	1	21	4	28	17	31	23	4	11

INTERESTS 1

ABILITIES 2

VALUES 3

NAME [redacted]

INSTITUTION or OCCUPATION ________ AGE ____ SEX ____ DATE ________

GRADE or CLASS ________

1663

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STRONG VOCATIONAL INTEREST BLANKS

PROFILE REPORT FOR: [redacted]
ID:
AGE: 27 **SEX:** F

DATE TESTED: 01/24/96
DATE SCORED: 2/ 7/96

SPECIAL SCALES: ACADEMIC COMFORT 48
INTROVERSION-EXTROVERSION 49

TOTAL RESPONSES: 325 **INFREQUENT RESPONSES:** 7

GOT

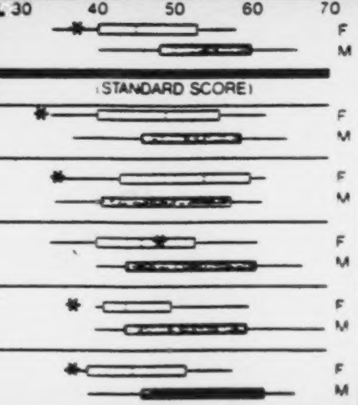
R	Mod. Low
I	Average
A	Mod. High
S	Average
E	Mod. Low
C	Low

REALISTIC

GENERAL OCCUPATIONAL THEME - R
Mod. Low 39

BASIC INTEREST SCALES (STANDARD SCORE)

Scale	Result	Score
AGRICULTURE	Low	34
NATURE	Low	37
ADVENTURE	Average	51
MILITARY ACTIVITIES	Very Low	40
MECHANICAL ACTIVITIES	Mod. Low	39

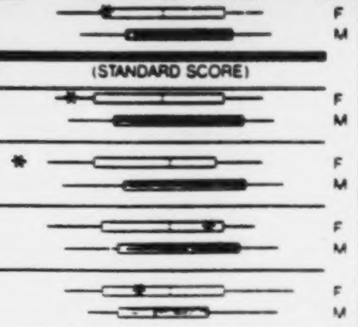


INVESTIGATIVE

GENERAL OCCUPATIONAL THEME - I
Average 43

BASIC INTEREST SCALES (STANDARD SCORE)

Scale	Result	Score
SCIENCE	Mod. Low	40
MATHEMATICS	Very Low	32
MEDICAL SCIENCE	Mod. High	57
MEDICAL SERVICE	Average	48



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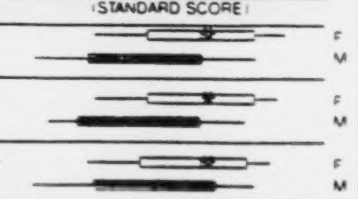
ARTISTIC

GENERAL OCCUPATIONAL THEME - A
Mod. High 60

BASIC INTEREST SCALES (STANDARD SCORE)

Scale	Result	Score
MUSIC/DRAMATICS	Average	56
ART	Average	57
WRITING	Average	56



OCCUPATIONAL SCALES

F	M	Occupation	Standard Score F	Standard Score M	Very Dissimilar	Dissimilar	Moderately Dissimilar	Mid-Range	Moderately Similar	Similar
		REALISTIC			15	25	30		40	45
(CRS)	RC	Marine Corps enlisted personnel	(CRS)	3						
RC	RC	Navy enlisted personnel	18	6		*				
RC	RC	Army officer	19	5		*				
R	RC	Navy officer	26	6			*			
R	R	Air Force officer	17	1		*				
(C)	R	Air Force enlisted personnel	(C)	7						
R	R	Police officer	18	7		*				
R	R	Bus driver	16	23		*				
R	R	Horticultural worker	26	18			*			
RC	R	Farmer	19	18		*				
R	RCS	Vocational agriculture teacher	13	-3	*					
RI	R	Forester	9	0	*					
(IR)	RI	Veterinarian	(IR)	11						
IRS	(SR)	Athletic trainer	6	(SR)	*					
RS	R	Emergency medical technician	10	9	*					
RI	RI	Radiologic technologist	20	18		*				
RI	R	Carpenter	10	10	*					
RI	R	Electrician	11	4	*					
RIA	(ARI)	Architect	19	(ARI)		*				
RI	RI	Engineer	19	9		*				
		INVESTIGATIVE			15	25	30		40	45
IRC	IRC	Computer programmer	24	19		*				
IRC	IRC	Systems analyst	22	16		*				
IRC	IR	Medical technologist	17	12		*				
IR	IR	R & D manager	23	7		*				
IR	IR	Geologist	9	26	*					
IR	(I)	Biologist	3	(I)	*					
IR	IR	Chemist	7	12	*					
IR	IR	Physicist	-2	5	*					
IR	(RI)	Veterinarian	19	(RI)		*				
IRS	IR	Science teacher	9	10	*					
IRS	IRS	Physical therapist	20	9		*				
IR	IRS	Respiratory therapist	22	17		*				
IC	IR	Medical technician	15	4		*				
IC	IE	Pharmacist	23	25		*				
ISR	(CSE)	Dietitian	23	(CSE)		*				
(SI)	ISR	Nurse, RN	(SI)	21						
IR	I	Chiropractor	18	41		*				
IR	IR	Optometrist	26	23			*			
IR	IR	Dentist	22	12		*				
I	IA	Physician	17	22		*				
(IR)	I	Biologist	(IR)	25						
I	I	Mathematician	6	18	*					
IA	I	Geographer	23	30		*				
I	I	College professor	29	42			*			
IA	IA	Psychologist	32	39				*		
IA	IA	Sociologist	23	36		*				
		ARTISTIC			15	25	30		40	45
AI	AI	Medical illustrator	32	36				*		
A	A	Art teacher	19	50		*				
A	A	Artist, fine	46	49						*
A	A	Artist, commercial	46	55						*
AE	A	Interior decorator	43	56					*	
(RIA)	ARI	Architect	(RIA)	42						
A	A	Photographer	47	51						*
A	A	Musician	46	56						*
AE	(EA)	Chef	25	(EA)			*			
(E)	AE	Beautician	(E)	60						
AE	A	Flight attendant	37	55				*		
A	A	Advertising executive	50	61						
A	A	Broadcaster	55	59						
A	A	Public relations director	37	46				*		
A	A	Lawyer	39	37				*		
A	AS	Public administrator	30	37				*		
A	A	Reporter	41	48					*	
A	A	Librarian	34	52				*		
AS	AS	English teacher	36	49				*		
(SA)	AS	Foreign language teacher	(SA)	45						

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STRONG INTEREST INVENTORY OF THE
STRONG VOCATIONAL INTEREST BLANKS

PROFILE REPORT FOR: [redacted]
ID:
AGE: 27 SEX: F

DATE TESTED: 01/24/96
DATE SCORED: 2/ 7/96

SOCIAL

GENERAL OCCUPATIONAL THEME - S
Average 44

BASIC INTEREST SCALES

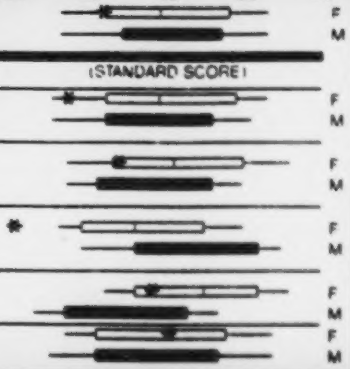
TEACHING
Mod. Low 40

SOCIAL SERVICE
Average 45

ATHLETICS
Very Low 31

DOMESTIC ARTS
Average 49

RELIGIOUS ACTIVITIES
Average 53



ENTERPRISING

GENERAL OCCUPATIONAL THEME - E
Mod. Low 41

BASIC INTEREST SCALES

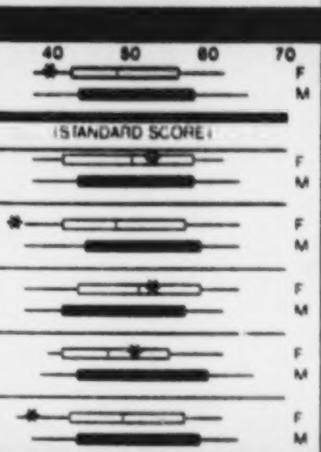
PUBLIC SPEAKING
Average 54

LAW/POLITICS
Low 36

MERCHANDISING
Average 54

SALES
Mod. High 53

BUSINESS MANAGEMENT
Mod. Low 38

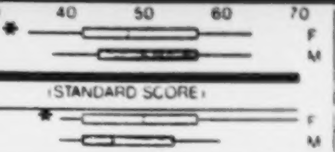


CONVENTIONAL

GENERAL OCCUPATIONAL THEME - C
Low 35

BASIC INTEREST SCALES

OFFICE PRACTICES
Low 39



OCCUPATIONAL SCALES

F	M		STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR
SOCIAL					15	25	30		40	45
SA	(AS)	Foreign language teacher	21	(AS)		*				
SA	SA	Minister	27	38			*			
SA	SA	Social worker	28	42			*			
S	S	Guidance counselor	26	32			*			
S	S	Social science teacher	21	29		*				
S	S	Elementary teacher	15	-5		*				
S	S	Special education teacher	18	12		*				
SRI	SAR	Occupational therapist	22	34		*				
SIA	SAI	Speech pathologist	34	41				*		
SI	(ISR)	Nurse, RN	25	(ISR)			*			
SEI	N/A	Dental hygienist	30	N/A				*		
SC	SC	Nurse, LPN	14	29	*					
(RIS)	SR	Athletic trainer	(RIS)	11						
SR	SR	Physical education teacher	-1	-10	*					
SRE	SE	Recreation leader	26	28			*			
SE	SE	YWCA/YMCA director	18	25		*				
SEC	SCE	School administrator	22	15		*				
SCE	N/A	Home economics teacher	10	N/A	*					
ENTERPRISING					15	25	30		40	45
E	ES	Personnel director	23	16		*				
ES	E	Elected public official	21	34		*				
ES	ES	Life insurance agent	25	17			*			
EC	E	Chamber of Commerce executive	20	24		*				
EC	EC	Store manager	38	37				*		
N/A	ECR	Agribusiness manager	N/A	4						
EC	EC	Purchasing agent	21	17		*				
EC	E	Restaurant manager	27	31			*			
(AR)	EA	Chef	(AR)	32						
EC	E	Travel agent	20	44		*				
ECS	E	Funeral director	30	27				*		
(CSE)	ESC	Nursing home administrator	(CSE)	26						
EC	ER	Optician	29	24			*			
E	E	Realtor	27	24			*			
E	(AE)	Beautician	29	(AE)			*			
E	E	Florist	40	34					*	
EC	E	Buyer	27	45			*			
EI	EI	Marketing executive	37	44				*		
EC	ECI	Investments manager	26	27			*			
CONVENTIONAL					15	25	30		40	45
C	C	Accountant	14	10	*					
C	C	Banker	24	19		*				
CE	CE	IRS agent	14	4	*					
CES	CES	Credit manager	14	2	*					
CES	CES	Business education teacher	1	17	*					
(CS)	CES	Food service manager	(CS)	24						
(ISR)	CSE	Dietitian	(ISR)	32						
CSE	(ESC)	Nursing home administrator	17	(ESC)		*				
CSE	CSE	Executive housekeeper	18	20		*				
CS	(CES)	Food service manager	21	(CES)		*				
CS	N/A	Dental assistant	17	N/A		*				
C	N/A	Secretary	16	N/A		*				
C	(R)	Air Force enlisted personnel	12	(R)	*					
CRS	(RC)	Marine Corps enlisted personnel	10	(RC)	*					
CRS	CR	Army enlisted personnel	18	3		*				
CIR	CIR	Mathematics teacher	4	8	*					

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ADMINISTRATIVE INDEXES (RESPONSE %)

OCCUPATIONS	23 L %	19 I %	58 D %
SCHOOL SUBJECTS	36 L %	19 I %	44 D %
ACTIVITIES	39 L %	31 I %	29 D %
LEISURE ACTIVITIES	41 L %	23 I %	36 D %
TYPES OF PEOPLE	33 L %	29 I %	38 D %
PREFERENCES	57 L %	27 = %	17 R %
CHARACTERISTICS	43 Y %	21 ? %	36 N %
ALL PARTS	34 %	23 %	43 %

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STRONG INTEREST INVENTORY OF THE
STRONG VOCATIONAL INTEREST BLANKS

PROFILE REPORT FOR: [redacted]
ID:
AGE: 27
SEX: F

DATE TESTED: 01/24/96
DATE SCORED: 2/ 7/96

SPECIAL SCALES: ACADEMIC COMFORT 48
INTROVERSION-EXTROVERSION 49

TOTAL RESPONSES: 325 INFREQUENT RESPONSES: 7

GOT

R	Mod. Low
I	Average
A	Mod. High
S	Average
E	Mod. Low
C	Low

OCCUPATIONAL SCALES

REALISTIC

GENERAL OCCUPATIONAL THEME - R
Mod. Low 39

BASIC INTEREST SCALES (STANDARD SCORE)

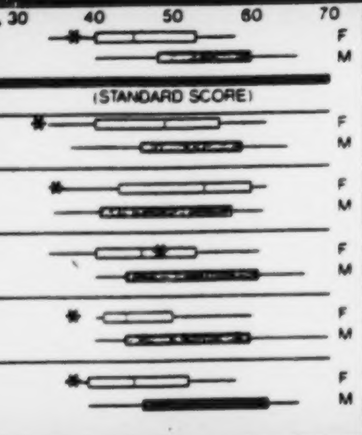
AGRICULTURE
Low 34

NATURE
Low 37

ADVENTURE
Average 51

MILITARY ACTIVITIES
Very Low 40

MECHANICAL ACTIVITIES
Mod. Low 39



F	M	OCCUPATIONAL SCALES	STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR
					15	25	30		40	45
(CRS)	RC	Marine Corps enlisted personnel	(CRS)	3						
RC	RC	Navy enlisted personnel	18	6		*				
RC	RC	Army officer	19	5		*				
RI	RIC	Navy officer	26	6			*			
R	R	Air Force officer	17	1		*				
(C)	R	Air Force enlisted personnel	(C)	7						
R	R	Police officer	18	7		*				
R	R	Bus driver	16	23		*				
R	R	Horticultural worker	26	18			*			
RC	R	Farmer	19	18		*				
R	RCS	Vocational agriculture teacher	13	-3	*					
RI	R	Forester	9	0	*					
(IR)	RI	Veterinarian	(IR)	11						
RS	(SR)	Athletic trainer	6	(SR)	*					
RS	R	Emergency medical technician	10	9	*					
RI	RI	Radiologic technologist	20	18		*				
RI	R	Carpenter	10	10	*					
RI	R	Electrician	11	4	*					
RIA	(ARI)	Architect	19	(ARI)		*				
RI	RI	Engineer	19	9		*				

INVESTIGATIVE

GENERAL OCCUPATIONAL THEME - I
Average 43

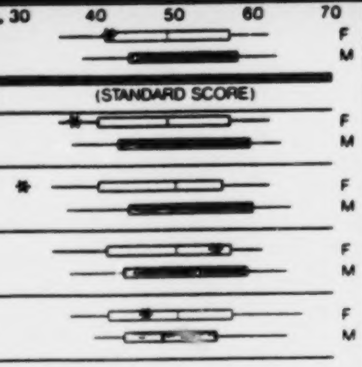
BASIC INTEREST SCALES (STANDARD SCORE)

SCIENCE
Mod. Low 40

MATHEMATICS
Very Low 32

MEDICAL SCIENCE
Mod. High 57

MEDICAL SERVICE
Average 48



F	M	OCCUPATIONAL SCALES	STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR
IRC	IRC	Computer programmer	24	19		*				
IRC	IRC	Systems analyst	22	16		*				
IRC	IR	Medical technologist	17	12		*				
IR	IR	R & D manager	23	7		*				
IR	IR	Geologist	9	26	*					
IR	(I)	Biologist	3	(I)	*					
IR	IR	Chemist	7	12	*					
IR	IR	Physicist	-2	5	*					
IR	(RI)	Veterinarian	19	(RI)		*				
IRS	IR	Science teacher	9	10	*					
IRS	IRS	Physical therapist	20	9		*				
IR	IRS	Respiratory therapist	23	17		*				
IC	IR	Medical technician	15	4		*				
IC	IC	Pharmacist	23	25		*				
ISR	(CSE)	Dietitian	23	(CSE)		*				
(SI)	ISR	Nurse, RN	(SI)	21						
IR	I	Chiropractor	18	41		*				
IR	IR	Optometrist	26	23			*			
IR	IR	Dentist	22	12		*				
I	IA	Physician	17	22		*				
(IR)	I	Biologist	(IR)	25						
I	I	Mathematician	6	18	*					
IA	I	Geographer	23	30		*				
I	I	College professor	29	42			*			
IA	IA	Psychologist	32	39				*		
IA	IA	Sociologist	23	36		*				

BEST COPY AVAILABLE

ARTISTIC

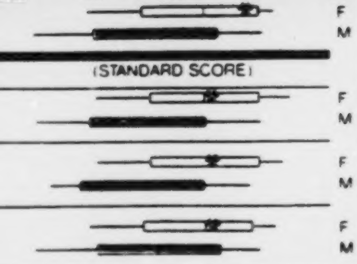
GENERAL OCCUPATIONAL THEME - A
Mod. High 60

BASIC INTEREST SCALES (STANDARD SCORE)

MUSIC/DRAMATICS
Average 56

ART
Average 57

WRITING
Average 56



F	M	OCCUPATIONAL SCALES	STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR
					15	25	30		40	45
AI	AI	Medical illustrator	32	36				*		
A	A	Art teacher	19	50		*				
A	A	Artist, fine	46	49						*
A	A	Artist, commercial	46	55						*
AE	A	Interior decorator	43	56					*	
(RIA)	ARI	Architect	(RIA)	42						
A	A	Photographer	47	51						*
A	A	Musician	46	56						*
AR	(EA)	Chef	25	(EA)			*			
(E)	AE	Beautician	(E)	60						
AE	A	Flight attendant	37	55				*		
A	A	Advertising executive	50	61						[illegible]
A	A	Broadcaster	55	59						[illegible]
A	A	Public relations director	37	46				*		
A	A	Lawyer	39	37				*		
A	AS	Public administrator	30	37				*		
A	A	Reporter	41	48					*	
A	A	Librarian	34	52				*		
AS	AS	English teacher	36	49				*		
(SA)	AS	Foreign language teacher	(SA)	45						

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# VINCENT INTERPRETIVE REPORT
for the MMPI
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Ken R. Vincent, Ed.D
published by
Pacific Psychological
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Name/ID:
Age: 27 Sex: Female Date: 06-05-96

This computer generated report should be considered a professional-to-professional consultation. All statements should be considered tentative and subject to further interpretation by a qualified mental health professional.

PROFILE VALIDITY

On the MMPI the person's validity scale configuration indicates the profile is valid and that the person is currently experiencing a significant amount of emotional distress.

PROFILE INTERPRETATION

Persons of this profile type typically are obsessive, worrisome, oversensitive individuals who are apt to present with complaints of anxiety, nervousness, tension, and depression. They almost always show marked psychic distress on admission and are apt to complain of difficulty in thinking and concentration. Occasionally they are quite confused and in a state of panic. These persons are overideational in approach to solving problems and are generally worrisome, insecure and have chronic feelings of inadequacy and inferiority. They are apt to be indecisive and passive in their relationships with others, and typically have difficulty establishing close interpersonal ties with the opposite sex. A rich fantasy life, and much daydreaming are characteristic of patients of this profile type. Sexual conflict and poor sexual performance are quite likely. These persons are apt to be withdrawn, depressed, and suffer from somatic correlates of anxiety. They are usually conscientious, but somewhat stereotyped in their approach to solving problems. Occasionally these persons drink excessively in an attempt to relax. Delusions and hallucinations are sometimes present. These persons may suffer from depersonalization. In state hospital settings, the majority of these persons are seen as psychotic and these are divided between major depressions and schizophrenia. In a recent study of private psychiatric patients, these persons were not seen as a homogenous group, and had a primary diagnosis of adjustment disorders; tied for second place, were three categories: Psychotic disorders not elsewhere classified (schizophreniform or schizoaffective disorders), affective disorders, and substance abuse. Though the latter was a small factor in primary classification, substance abuse was included as a primary, secondary or tertiary diagnosis in 64% of this sample. This is greater than normally has been reported in the general literature with the exception of work that has been done with female college students. The modal personality cluster for patients of this profile type was dramatic, emotional, erratic personality disorders; namely, borderline or histrionic. This differs from previous findings; however, here again this was not a homogenous sample and the differential would include schizoid, schizotypal, avoidant and passive-aggressive.

PERSONALITY (AXIS II)

The elevated score of the STY Personality Disorder Scale indicates a Schizotypal Personality Disorder. Individuals with Schizotypal Personality Disorders tend to be isolated and aloof. They do desire some contact with others but want to avoid contact that they cannot cope with comfortably and often experience social anxiety. They have recurrent illusions, engaging magical thinking, and ideas of reference which seem to be coping mechanisms to fill their inner void. Their affect is often constricted or incongruent with their circumstance.

They tend to experience life as flat and lifeless. They feel disembodied and often have dissociative experiences. They are detached, uninvolved observers of the world and others. Their behavior and appearance is often odd or eccentric. They are overwhelmed by the fear of disintegration and non-existance. As depersonalization becomes more severe, psychotic episodes are more likely, as are irrational outbursts.

When social demands and expectations press upon them, they feel an excess of environmental stimulation. They often react to this by dissociating, or in extreme cases by use of paranoia and aggressive outbursts. They may also react with delusional thoughts, hallucinations and bizarre behaviors.

When they are called upon to relate to others, they often do not logically orient their thoughts. They become lost, tangential, and digressive. This particular speech pattern only causes them more alienation from others. They are often never married and tend to drift from job to job.

Other personality patterns often associated with the Schizotypal personality are the schizoid and avoidant patterns.

Slight elevation of the BDL Personality Disorder Scale indicates a Borderline Personality Type. These individuals have been described as having intense affect and rapidly changing moods and actions. Their behavior is erratic and unpredictable.

They have difficulty maintaining a sense of self and seem to lack a clear personal identity. They feel scattered, and therefore vacillate among their whims and fantasies. They are often attached to another person and become dependent upon them. They are vulnerable to loss and afraid of being alone. They are fearful of rejection and often misinterpret the actions of others as rejection. They may experience anger towards those they depend upon. The stronger their angry feelings become the more prevalent and serious their potential to harm themselves becomes.

Slight elevation of the PAG Personality Disorder Scale indicates a Passive-Aggressive Personality Type. A person with a passive-aggressive personality pattern tends to be negativistic. They sometimes appear sullen and easily offended by others. Their feelings are often unstable and they have a low tolerance for frustration. They are jealous, quarrelsome people who begrudge others their successes. They are unpredictable, and at times volatile.

They often complain about their subjective or somatic discomforts but usually do not want to explore to gain insight into their origin. These individuals are preoccupied with their sense of personal inadequacy, bodily ailments, feelings of guilt, social resentments, frustrations, and disillusionments. They feel victimized by fate and think that nothing ever works out for them.

They have difficulty working out their moods, desires and thoughts internally. As children they generally did not have consistent discipline. Because of this they do not have a sense of self discipline. These individuals generally employ two defense mechanisms, introjection and projection.

SPECIAL SCALE INTERPRETATION

The person has a significant elevation on the Anxiety (A) supplemental scale. Such individuals are apt to be consciously anxious, especially in social situations. A lack of self assurance and trust in oneself is likely. The person is apt to be pessimistic about the future, but because of emotional discomfort is motivated for treatment.

The person has a significant elevation on the Subjective Depression (D1) Harris subscale. These individuals generally feel depressed or unhappy most of the time. They lack energy and drive and do not cope with everyday life very well. They feel nervous and tense most of the time and have difficulty concentrating. They lack self confidence, feel inferior to others, and are easily hurt by criticism. They avoid interaction with others and are often embarassed in social situations. They will often manifest a multiplicity of depressed symptoms including: poor appetite, sleep disturbance, frequent crying, and depressed mood. They are often diagnosed as having a dysthymic disorder.

The person has a significant elevation on the Brooding (D5) Harris subscale. These individuals feel inferior, unhappy and useless. They are generally hurt by criticism and tend to brood and ruminate over past social encounters. They generally lack the energy to cope with problems and often feel like they are losing control of their minds.

The person has a significant low score on the Denial of Social Anxiety (Hy1) Harris subscale. These individuals are generally introverted and are influenced greatly by social standards and customs. They are somewhat shy in social situations and have a difficult time talking to others.

The person has a significant low score on the Need for Affection (Hy2) Harris subscale. These individuals generally see others as dishonest, selfish, and unreasonable. They are critical and suspicious of others, and generally perceive others as treating them badly.

The person has a significant elevation on the Lassitude-Malaise (Hy3) Harris subscale. Individuals with this profile type may not be in good health and generally feel weak, fatigued, or tired. They have difficulty concentrating and may manifest poor appetite and sleep disturbance. They are bored, uninterested in their environment and tend to be somewhat unhappy and depressed most of the time.

The person has a significant elevation on the Familial Discord (Pd1) Harris subscale. These individuals see their home situation as unpleasant and lacking in love, understanding and support. They describe their family as critical, quarrelsome, and overbearing. They often feel like leaving their home situation.

The person has a significant elevation on the Social Alienation (Pd4A) Harris subscale. These individuals feel alienated and socially isolated. They feel lonely, unhappy and unloved. They in general feel that people do not understand them and feel like they have received a raw deal from life. They are self centered, insensitive in needs and feelings of others and are often inconsiderate. However, paradoxically they are concerned about what others think about them. They often express regret and remorse for their actions which is usually short lived.

The person has a significant elevation on the Self-Alienation (Pd4B) Harris subscale. These individuals seem to be uncomfortable and unhappy. Often times they have problems concentrating. They see their daily life as uninteresting and unrewarding. They verbalize regret, guilt and remorse over their past deeds and shortcomings. They generally do not talk about the specific misbehaviors that concern them. Many of these individuals use alcohol excessively.

The person has a significant elevation on the Poignancy (Pa2) Harris subscale. These individuals appear to be high strung and more sensitive than most individuals. They see themselves as intensive people who often feel lonely and generally misunderstood. Their high energy level and need for sensory stimulation often drive them toward risky and exciting activities. This results in tension discharge and temporary equilibrium.

The person has a significant elevation on the Social Alienation (Sc1A) Harris subscale. These individuals describe their family situation as lacking in love and support. They feel that their families treat them more like children than adults. They often report having feelings of hostility and hatred toward family members. They are extremely alienated and feel that others do not understand them. In some cases they actually feel that some people are trying to harm them or are out to get them. Because of their fear and social phobia they tend to avoid social situations and interpersonal relationships when at all possible. They consequently feel lonely and empty inside.

The person has a significant elevation on the Lack of Ego Mastery, Cognitive (Sc2A) Harris subscale. These individuals generally have difficulty concentrating and thinking. They also may have memory problems. They may report strange thought processes and have feelings of depersonalization and unreality. They often feel that they might be losing their minds.

The person has a significant elevation on the Lack of Ego Mastery, Conative (Sc2B) Harris subscale. These individuals are generally depressed and in a state of despair. When put in stressful situations they often become anxious and agitated. They have difficulty coping with everyday problems and worry excessively. Their general defense against stress is to withdraw into fantasy and daydreaming. Many times they wish that they were dead, and they seem to have given up hope.

The person has a significant elevation on the Lack of Ego Mastery, Defective Inhibition (Sc2C) Harris subscale. These individuals report having dissociative episodes and memory blackouts. They appear to be restless and irritable and may have periods of laughing and crying which they can not control. They feel like they cannot control their emotions and impulses and are frightened by this loss of control.

The person has a significant low score on the Socially Retiring (Mf6) Serkownek subscale. These individuals are extroverted, exhibitionistic and like to be the center of attention. They are dogmatic and argumentative. They often seek sensory stimulation and are often involved in risky or dangerous activities.

The person has a significant low score on the Staid-Personal Rigidity (Si3) Serkownek subscale. The individuals enjoy social groups and clubs, seek out excitement, and are extremely competitive. At times they may become hyperactive, and at extremes, hypomanic. They often blame others for their misfortunes.

The person has a significant elevation on the Physical-Somatic Concerns (Si6) Serkownek subscale. These individuals commonly report somatic symptoms including changing in speech and hearing, hay fever and asthma. They tend to worry and are concerned about their physical appearance. They tend to be socially introverted and to avoid problematical social situations.

The person has a significant elevation on the Psychoticism (PSY) Wiggins' Content scale. These individuals may manifest a variety of psychotic symptoms including hallucinations, confused thinking, unusual thought content and mannerisms, paranoid ideation, and lack of control. Most feel misunderstood and persecuted by others and society. They often respond to what they perceive as a threat by withdrawing into fantasy and daydreaming. They are generally somewhat grandiose and are unrealistic concerning their own abilities and talents.

The person has a significant elevation on the Manifest Hostility (HOS) Wiggins' Content scale. These individuals are apt to be hostile and aggressive. They may also express these impulses in passive, indirect ways. They are often practical jokers, generally uncooperative, and very critical of others. They see other individuals as extremely demanding and resent the demands placed upon them. They feel like they are being taken advantage of and tend to retaliate indiscriminantly against others they perceive as taking advantage of them. They exhibit an extreme amount of interpersonal sensitivity and are apt to be argumentative.

The person has a significant elevation on the Poor Health (HEA) Wiggins' Content scale. These individuals express concern over their physical health. They are often preoccupied with their physical condition and exhibit gastro-intestinal difficulties. They may complain of coughing, heart pain, hay fever, asthma, shortness of breath, sexual difficulty and fatigue.

The person has a significant elevation on the Depression (IV) TSC Cluster scale. These individuals are generally depressed and apathetic. They also feel anxious and fearful. They may exhibit depressive symptoms which include unhappiness, psychomotor retardation, feeling blue, lacking energy, fatigue, loss of interest, suicidal ideation or fear of losing control. They have extremely low self concepts and feel that the life situation has become so problematical and difficult that they no longer have the resources to cope. They see life as uninteresting and unrewarding. They often feel like complete failures and express fear and guilt.

The person has a significant elevation on the Autism (VI) TSC Cluster scale. These individuals may exhibit psychotic thought processes and symptoms. They often have strange, weird thoughts which they perceive as disturbing and frightening. They often have trouble concentrating, are indecisive and forgetful. They have feelings of unreality which may include dissociation and depersonalization. They also have daydreams which they may perceive as immoral or evil, and which they are reluctant to talk about. In times of stress they may manifest a psychotic disorder and thought disturbance.

The person has a significant elevation on the Tension (VII) TSC Cluster scale. These individuals are extremely anxious and nervous. They also manifest compulsive mechanisms and excessive worry. They are easily upset, often cry readily and manifest sleep disturbance and difficulty concentrating and may have specific fears such as claustrophobia and fear of natural disaster and disease.

MMPI-83 Scoring Report
Version 2.0

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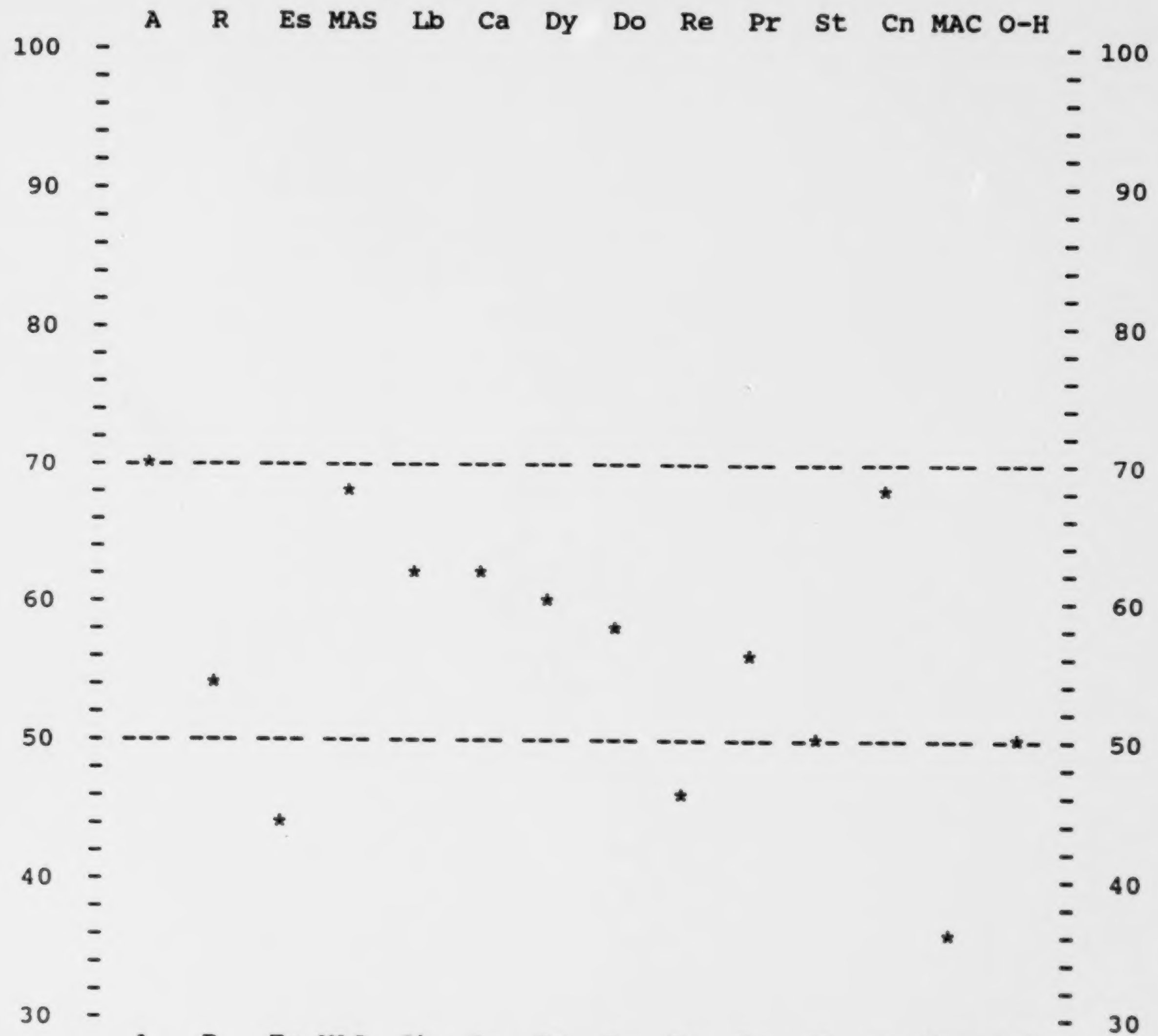
Name:
Age: 27 Sex: Female Date: 06-05-96

```
       L   F   K     Hs  D   Hy  Pd  Mf  Pa  Pt  Sc  Ma  Si
100 -             I                                         - 100
    -             I                                         -
    -             I                                         -
    -             I                                         -
    -             I                                         -
 90 -             I                                         - 90
    -             I                                         -
    -             I                                         -
    -             I                                         -
    -             I                                         -
 80 -             I                                         - 80
    -      *      I                              *          -
    -             I                          *              -
    -             I                                         -
    -             I                      *                  -
 70 - --- --- --- I --- --- --- --- --- --- --- --- --- --- - 70
    -             I      *       *                          -
    -             I                                         -
    -             I  *                                      -
    -             I                                         -
 60 -             I                                  *      - 60
    -             I                                         -
    -             I                                         -
    -             I          *                              -
    -             I                                         -
 50 - --- --- --- I --- --- --- --- --- --- --- --- --- -*- - 50
    -             I                                         -
    -         *   I                                         -
    -             I                  *                      -
    -             I                                         -
 40 -  *          I                                         - 40
    -             I                                         -
    -             I                                         -
    -             I                                         -
    -             I                                         -
 30 -             I                                         - 30
```

```
                      1    2    3    4    5    6    7    8    9    0
       L    F    K    Hs   D    Hy   Pd   Mf   Pa   Pt   Sc   Ma   Si
Raw     2   14   13   14   32   23   24   41   17   29   31   18   29
K-Corr                21             29             42   44   21
Tscore 41   78   46   65   69   54   68   44   72   76   78   60   50
```

This is a computer scoring report based primarily upon the 1983 census norms found in The MMPI, A Contemporary Normative Study by Colligan, Osborne, Swenson, and Offord. Permission was granted to use the "83" norms by Robert C. Colligan, Ph.D

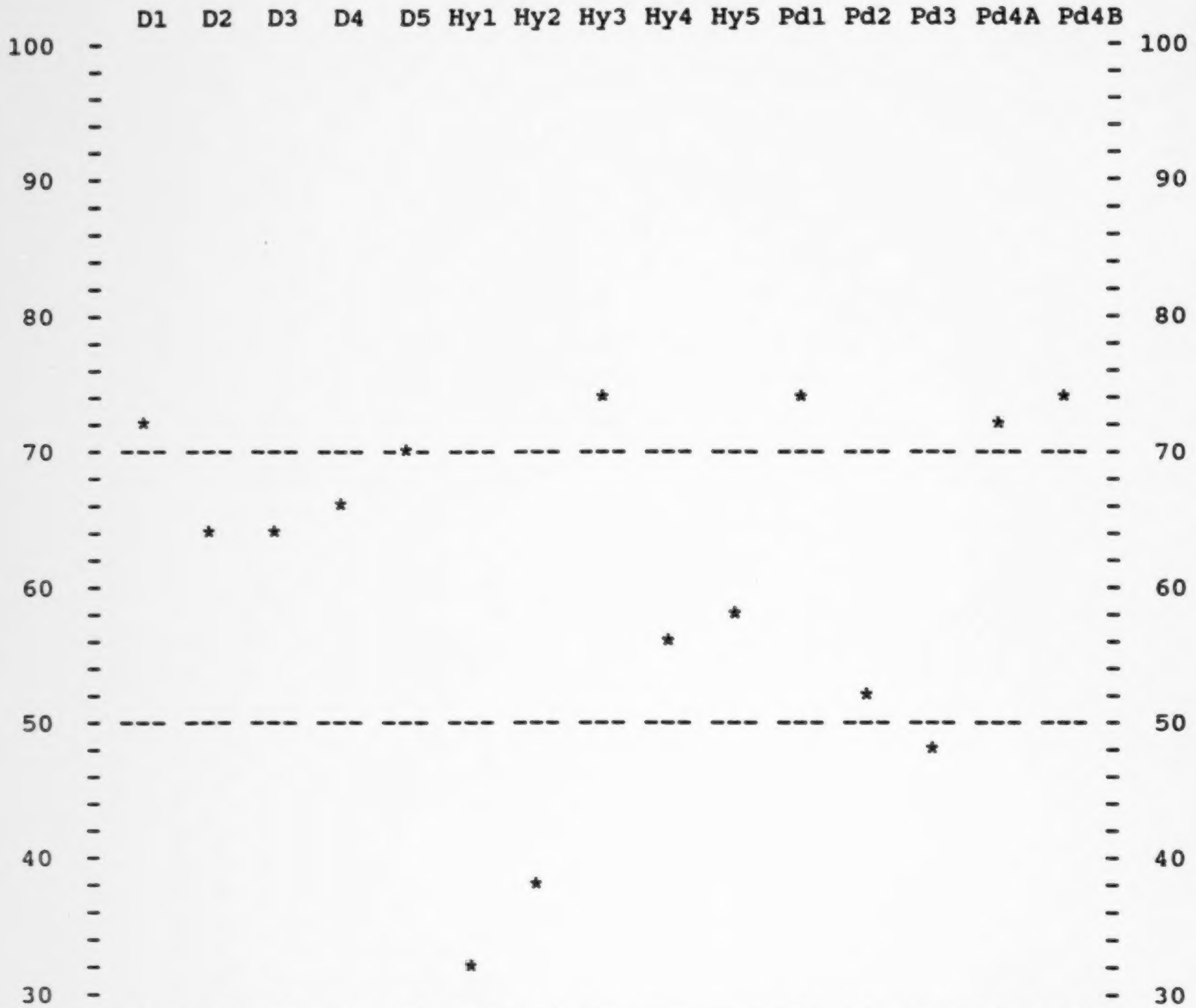
FREQUENTLY SCORED SCALES



	A	R	Es	MAS	Lb	Ca	Dy	Do	Re	Pr	St	Cn	MAC	O-H
Raw	27	20	40	30	13	18	31	19	21	13	20	32	16	15
T	70	54	45	68	63	63	60	58	46	56	51	68	37	51

A - Anxiety
MAS - Manifest Anxiety
Dy - Dependency
Pr - Prejudice
MAC - MacAndrews Alcoholism
R - Repression
Lb - Low Back Pain
Do - Dominance
St - Social Status
Es - Ego Strength
Ca - Caudality
Re - Social Responsibility
Cn - Control
O-H - Overcontrolled Hostility

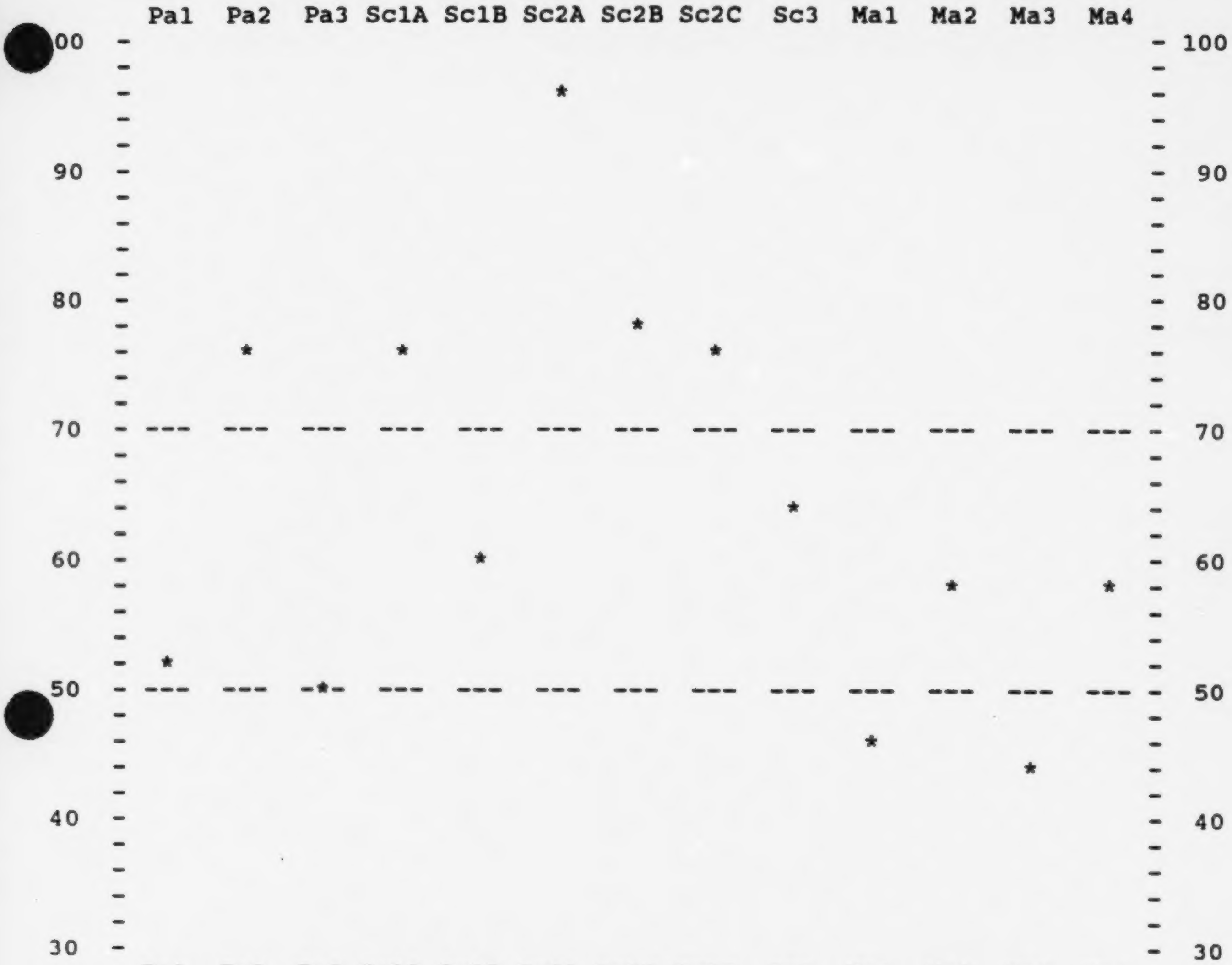
HARRIS SUBSCALES 1



	D1	D2	D3	D4	D5	Hy1	Hy2	Hy3	Hy4	Hy5	Pd1	Pd2	Pd3	Pd4A	Pd4B
Raw	17	9	5	6	6	0	4	8	5	5	6	4	6	11	9
T	73	64	65	66	70	33	39	75	56	59	75	53	48	73	75

D1 - Subjective Depression
D2 - Psychomotor Retardation
D3 - Physical Malfunctioning
D4 - Mental Dullness
D5 - Brooding
Hy1 - Denial of Social Anxiety
Hy2 - Need for Affection
Hy3 - Lassitude-Malaise
Hy4 - Somatic Complaints
Hy5 - Inhibition of Aggression
Pd1 - Familial Discord
Pd2 - Authority Problems
Pd3 - Social Imperturbability
Pd4A - Social Alienation
Pd4B - Self-Alienation

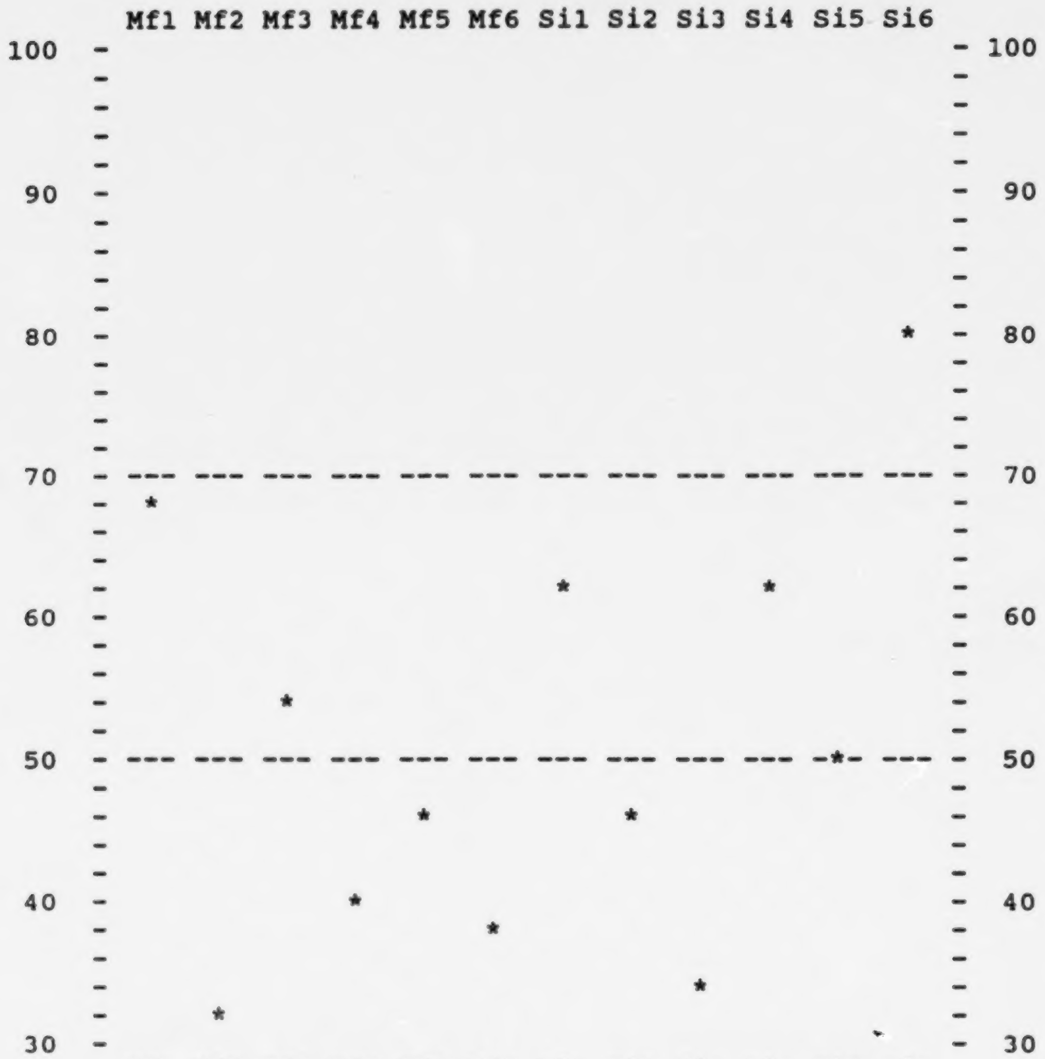
HARRIS SUBSCALES 2



	Pa1	Pa2	Pa3	Sc1A	Sc1B	Sc2A	Sc2B	Sc2C	Sc3	Ma1	Ma2	Ma3	Ma4
Raw	2	6	5	9	2	8	7	5	5	1	6	2	4
T	52	76	51	76	61	97	78	76	65	47	59	45	59

Pa1 - Persecutory Ideas Pa2 - Poignancy Pa3 - Naivete
Sc1A - Social Alienation Sc1B - Emotional Alienation
Sc2A - Lack of Ego Mastery, Cognitive Sc2B - Lack of Ego Mastery, Conative
Sc2C - Lack of Ego Mastery, Defective Inhibition
Sc3 - Bizarre Sensory Experiences Ma1 - Amorality
Ma2 - Psychomotor Acceleration Ma3 - Imperturbability Ma4 - Ego Inflation

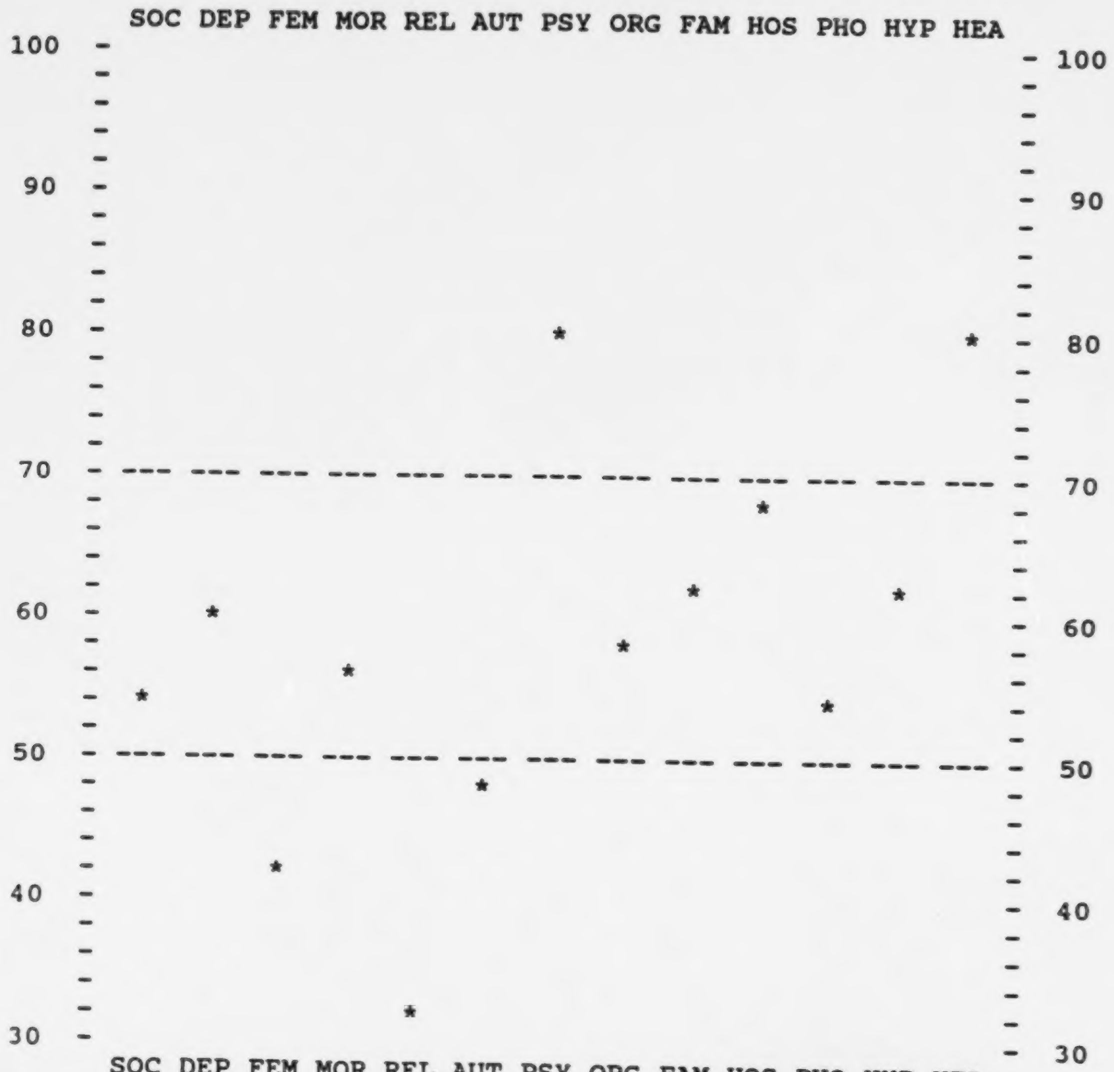
SERKOWNEK SUBSCALES



	Mf1	Mf2	Mf3	Mf4	Mf5	Mf6	Si1	Si2	Si3	Si4	Si5	Si6
Raw	12	5	7	2	3	3	18	3	6	6	5	6
T	68	32	55	41	47	38	63	46	35	63	51	80

Mf1 - Narcissism-Hypersensitivity
Mf2 - Stereotypic Feminine Interests
Mf3 - Denial of Stereotypic Masculine Interests
Mf4 - Heterosexual Discomfort-Passivity
Mf5 - Introspective-Critical
Mf6 - Socially Retiring
Si1 - Inferiority-Personal Discomfort
Si2 - Discomfort With Others
Si3 - Staid-Personal Rigidity
Si4 - Hypersensitivity
Si5 - Distrust
Si6 - Physical-Somatic Concerns

WIGGINS' CONTENT SCALES



	SOC	DEP	FEM	MOR	REL	AUT	PSY	ORG	FAM	HOS	PHO	HYP	HEA
Raw	14	12	18	12	3	7	20	9	7	14	12	16	16
T	55	61	43	57	32	49	81	59	62	68	55	62	80

SOC - Social Maladjustment
FEM - Feminine Interests
REL - Religious Fundamentalism
PSY - Psychoticism
FAM - Family Problems
PHO - Phobias
HEA - Poor Health

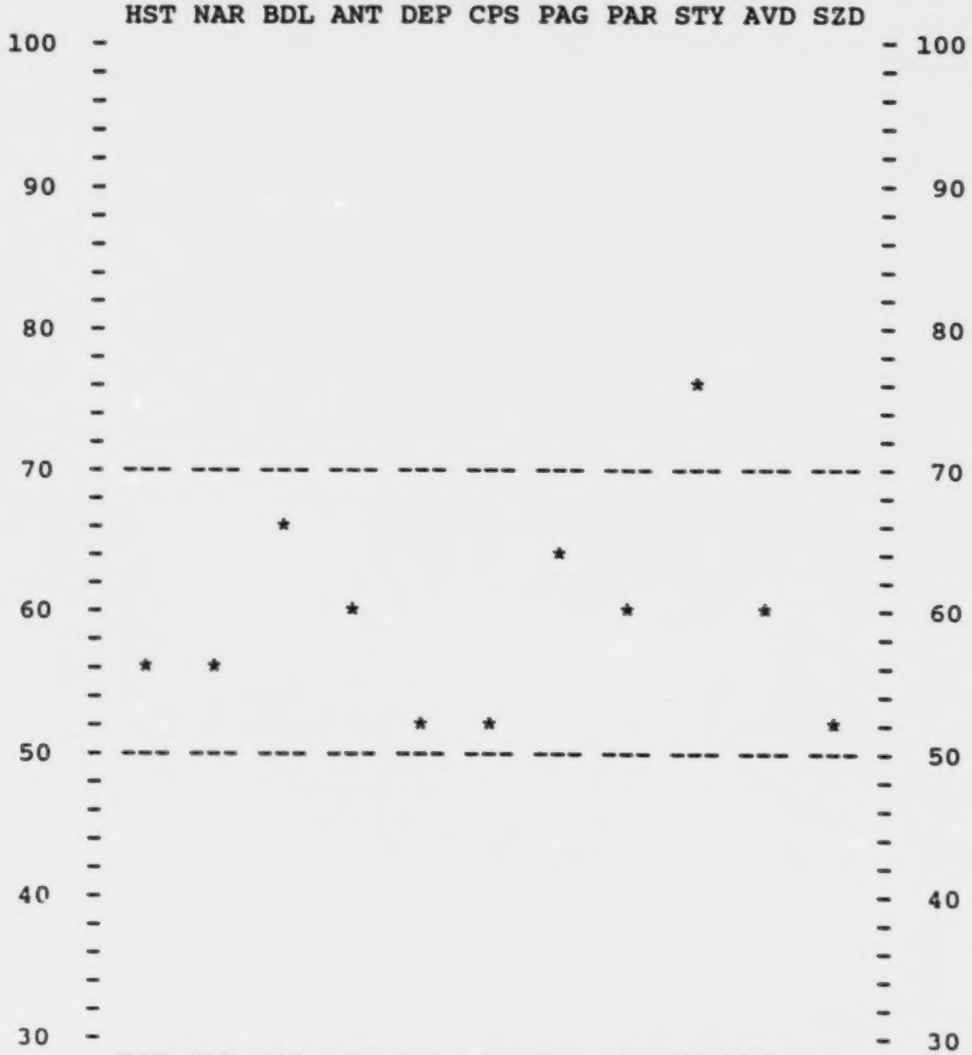
DEP - Depression
MOR - Poor Morale
AUT - Authority Conflict
ORG - Organic Symptoms
HOS - Manifest Hostility
HYP - Hypomania

```
              TSC CLUSTER SCALES

        I    II  III   IV   V    VI  VII
100  -                                   - 100
     -                                   -
     -                                   -
     -                                   -
     -                                   -
 90  -                                   - 90
     -                                   -
     -                                   -
     -                                   -
     -                                   -
 80  -                                   - 80
     -                                   -
     -                                   -
     -                                   -
     -                                   -
 70  - ---  ---  ---  ---  ---  -*-  ---  - 70
     -                                *  -
     -                 *                 -
     -       *                           -
     -                                   -
 60  -                                   - 60
     -                      *            -
     -                                   -
     -  *         *                      -
     -                                   -
 50  - ---  ---  ---  ---  ---  ---  ---  - 50
     -                                   -
     -                                   -
     -                                   -
     -                                   -
 40  -                                   - 40
     -                                   -
     -                                   -
     -                                   -
     -                                   -
 30  -                                   - 30
        I    II  III   IV   V    VI  VII
Raw     14   13   12   14    9   14   21
T       55   64   54   66   58   70   68

I - Introversion  II - Body Symptoms  III - Suspicion  IV - Depression
V - Resentment    VI - Autism         VII - Tension
```

PERSONALITY DISORDER SCALES



	HST	NAR	BDL	ANT	DEP	CPS	PAG	PAR	STY	AVD	SZD
Raw	14	18	14	9	8	8	8	8	22	22	7
T	56	57	67	61	53	52	64	60	77	60	53

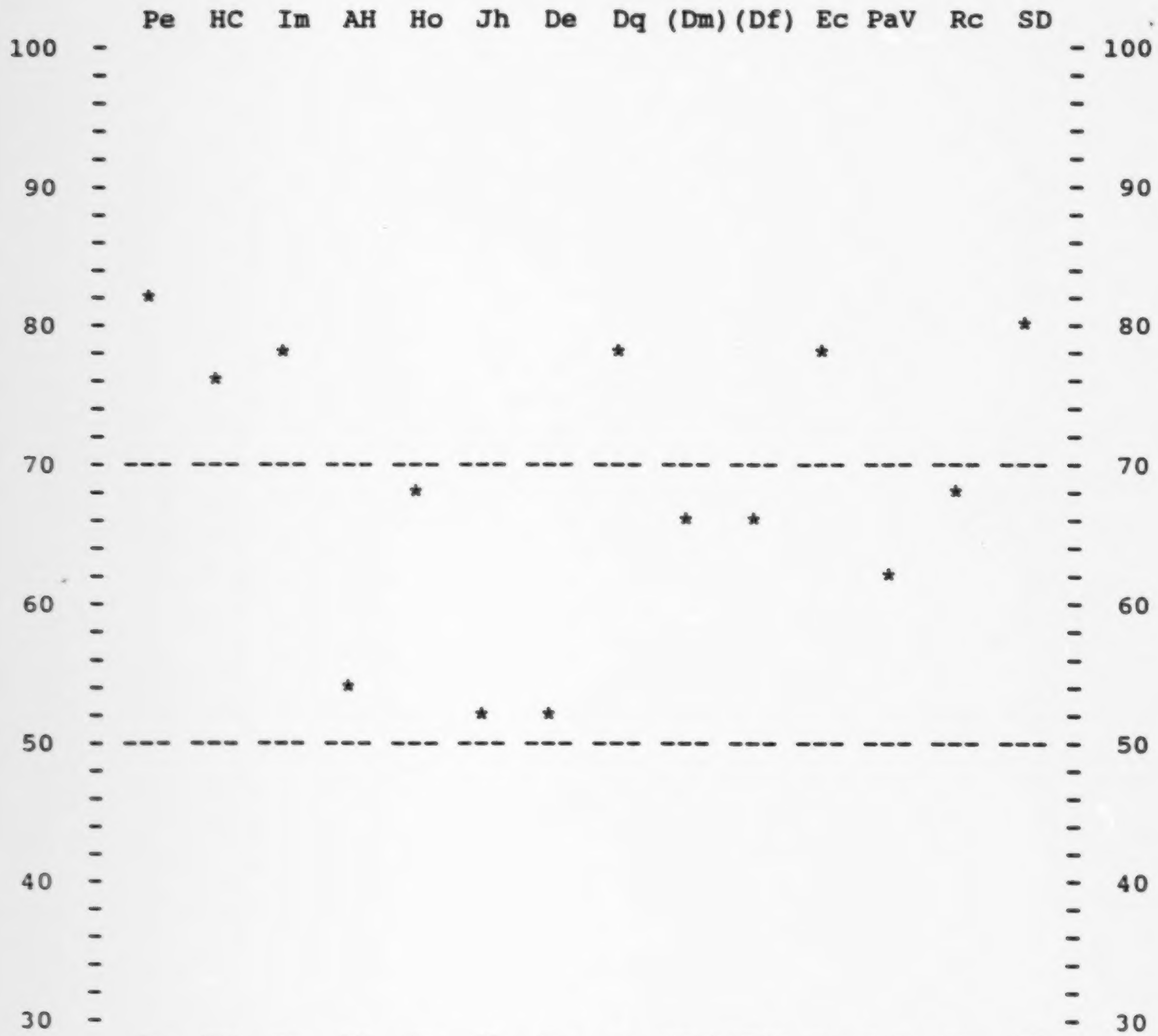
HST - Histrionic
ANT - Antisocial
PAG - Passive-Aggressive
AVD - Avoidant
NAR - Narcissistic
DEP - Dependent
PAR - Paranoid
SZD - Schizoid
BDL - Borderline
CPS - Compulsive
STY - Schizotypal

WEINER-HARMON SUBTLE-OBVIOUS SUBSCALES

```
      D-O  D-S  Hy-O Hy-S Pd-O Pd-S Pa-O Pa-S Ma-O Ma-S
100 -                                                   - 100
    -                                                   -
    -                                                   -
    -                                                   -
    -                                                   -
 90 -                                                   - 90
    -                                                   -
    -                                                   -
    -                                                   -
    -                                                   -
 80 -                                                   - 80
    -                                                   -
    -                                    *              -
    -                                                   -
    -                      *                            -
 70 - -*-  ---  ---  ---  ---  ---  ---  ---  ---  ---  - 70
    -                                                   -
    -                                                   -
    -                                                   -
    -            *                   *         *        -
 60 -                           *                       - 60
    -                                                   -
    -                                                   -
    -       *                                           -
    -                                                   -
 50 - ---  ---  ---  ---  ---  ---  ---  ---  ---  -*-  - 50
    -                                                   -
    -                                                   -
    -                 *                                 -
    -                                                   -
 40 -                                                   - 40
    -                                                   -
    -                                                   -
    -                                                   -
    -                                                   -
 30 -                                                   - 30
      D-O  D-S  Hy-O Hy-S Pd-O Pd-S Pa-O Pa-S Ma-O Ma-S
Raw     20   12   13   11   13   11    6   11    9    9
T       71   54   63   45   72   60   63   76   63   50

D-O - Depression-Obvious                  D-S - Depression-Subtle
Hy-O - Hysteria-Obvious                   Hy-S - Hysteria-Subtle
Pd-O - Psychopathic Deviate-Obvious       Pd-S - Psychopathic Deviate-Subtle
Pa-O - Paranoia-Obvious                   Pa-S - Paranoia-Subtle
Ma-O - Hypomania-Obvious                  Ma-S - Hypomania-Subtle
```

FORENSIC SCALES

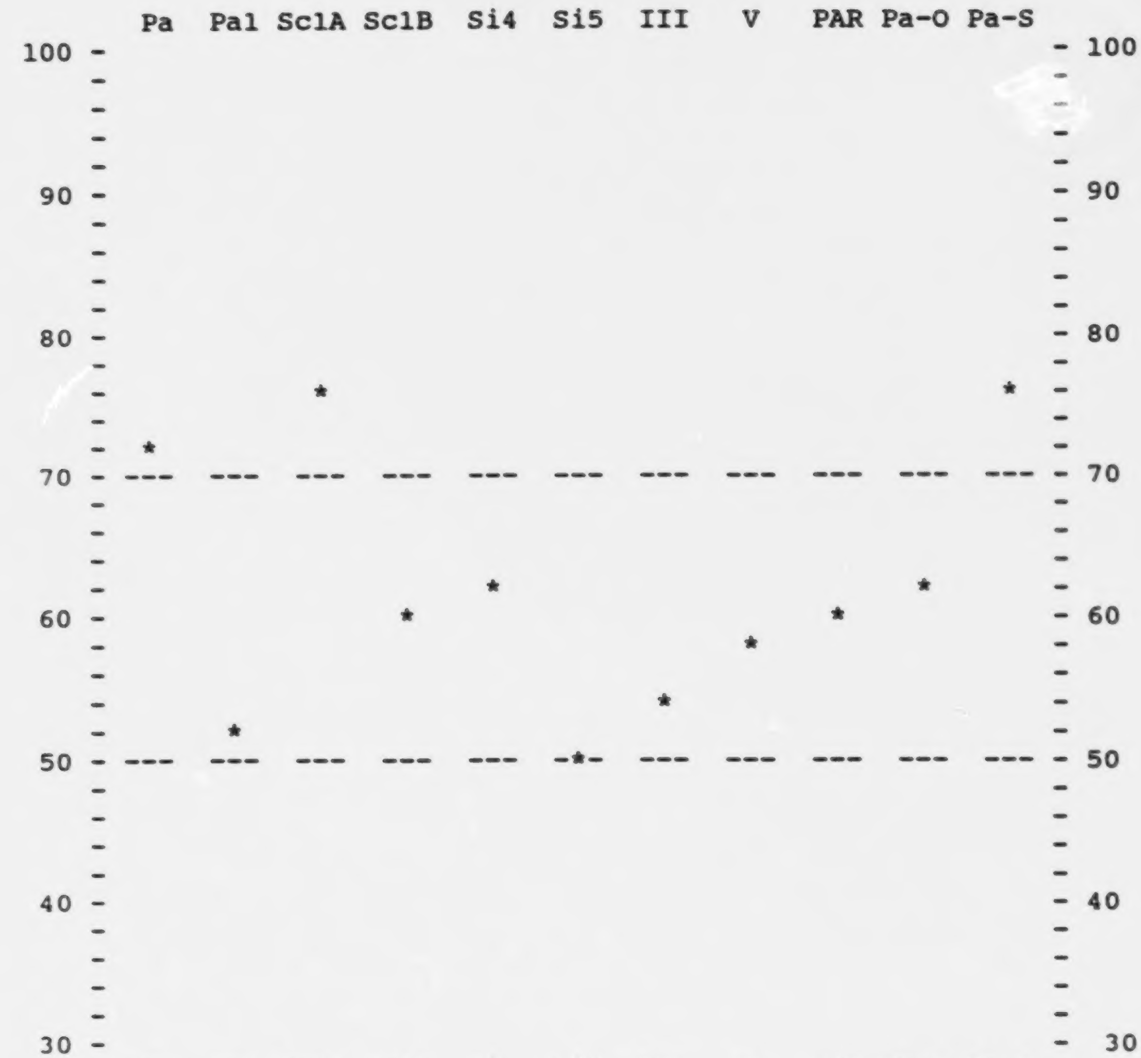


	Pe	HC	Im	AH	Ho	Jh	De	Dq	(Dm)	(Df)	Ec	PaV	Rc	SD
Raw	11	37	16	4	18	15	3	15	27	47	20	14	10	22
T	83	77	78	55	69	53	53	79	66	66	78	63	69	81

Pe - Pedophile
Im - Impulsivity
Ho - Hostility
De - Delinquency
(Dm) - Delinquency Males
Ec - Escapism
Rc - Recidivism

HC - Habitual Criminalism
AH - Acting-out Hostility
Jh - Judged Manifest Hostility
Dq - Delinquency
(Df) - Delinquency Females
PaV - Parole Violation
SD - Socialized Delinquency

Paranoid-Sensitivity

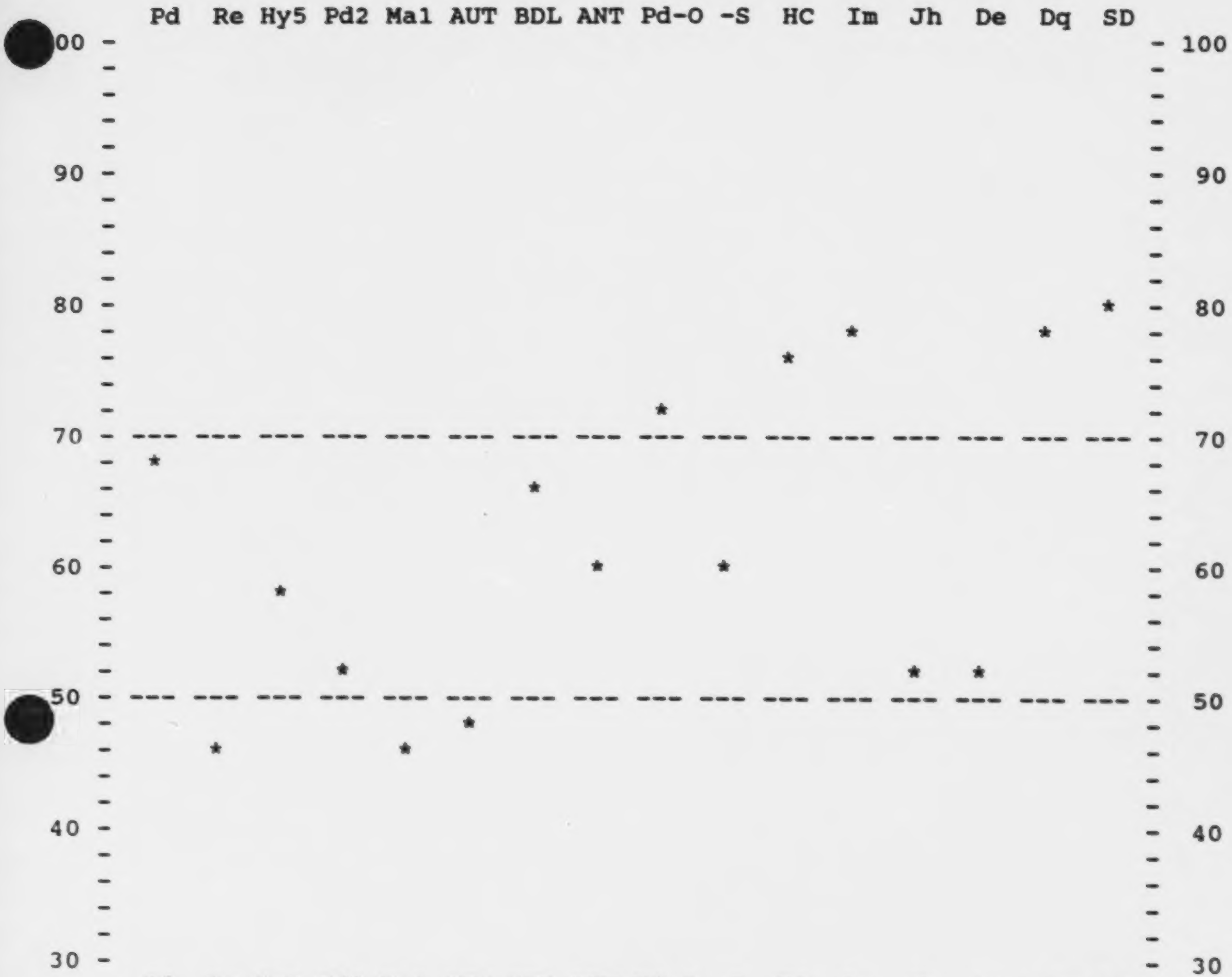


	Pa	Pa1	Sc1A	Sc1B	Si4	Si5	III	V	PAR	Pa-O	Pa-S
Raw	17	2	9	2	6	5	12	9	8	6	11
Tscore	72	52	76	61	63	51	54	58	60	63	76

Pa - Paranoia
Pa1 - Persecutory Ideas
Sc1A - Social Alienation
Sc1B - Emotional Alienation
Si4 - Hypersensitivity
Si5 - Distrust

TSC-III - Suspicion
TSC-V - Resentment
PAR - Paranoid
Pa-O - Paranoia-Obvious
Pa-S - Paranoia-Subtle

Antisocial - Impulse Control



	Pd	Re	Hy5	Pd2	Ma1	AUT	BDL	ANT	Pd-O	-S	HC	Im	Jh	De	Dq	SD
Raw	24	21	5	4	1	7	14	9	13	11	37	16	15	3	15	22
Tscore	68	46	59	53	47	49	67	61	72	60	77	78	53	53	79	81

Pd - Psychopathic Deviate
Re - Social Responsibility
Hy5 - Inhibition of Aggression
Pd2 - Authority Problems
Ma1 - Amorality
AUT - Authority Conflict
BDL - Borderline
ANT - Antisocial

Pd-O - Psychopathic Deviate-Obvious
Pd-S - Psychopathic Deviate-Subtle
HC - Habitual Criminalism
Im - Impulsivity
Jh - Judged Manifest Hostility
De - Delinquency
Dq - Delinquency
SD - Socialized Delinquency

```
                   Physical Complaints                Femininity

       Hs   Lb   Ca   Hy4  Si6  ORG  HEA  II    Mf   Mf2  Mf3  FEM
 100 -                                        I                     - 100
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
  90 -                                        I                     - 90
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
  80 -                     *         *        I                     - 80
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
  70 - ---  ---  ---  ---  ---  ---  ---  --- I ---  ---  ---  ---  - 70
     -                                        I                     -
     -                                        I                     -
     -  *                                  *  I                     -
     -       *    *                           I                     -
  60 -                                        I                     - 60
     -                          *             I                     -
     -                *                       I                     -
     -                                        I            *        -
     -                                        I                     -
  50 - ---  ---  ---  ---  ---  ---  ---  --- I ---  ---  ---  ---  - 50
     -                                        I                     -
     -                                        I                     -
     -                                        I  *                  -
     -                                        I                 *   -
  40 -                                        I                     - 40
     -                                        I                     -
     -                                        I                     -
     -                                        I                     -
     -                                        I       *             -
  30 -                                        I                     - 30
       Hs   Lb   Ca   Hy4  Si6  ORG  HEA  II    Mf   Mf2  Mf3  FEM
Raw    14   13   18    5    6    9   16   13    41    5    7   18
Tscore 65   63   63   56   80   59   80   64    44   32   55   43
```

Hs - Hypochondriasis
Lb - Low Back Pain
Ca - Caudality
Hy4 - Somatic Complaints
Si6 - Physical-Somatic Concerns
ORG - Organic Symptoms
HEA - Poor Health

TSC-II - Body Symptoms

Mf - Masculinity-Femininity
Mf2 - Stereotypic Feminine Interests
Mf3 - Denial of Stereotypic Masculine Interests
FEM - Feminine Interests

```
                     Depression                       Social Introversion

        D     D1    DEP   IV    D-O   D-S      Si    St    Hy1   Pd4A  Mf6   Si2   I
100  -                                      I                                             -  100
     -                                      I                                             -
     -                                      I                                             -
     -                                      I                                             -
     -                                      I                                             -
 90  -                                      I                                             -  90
     -                                      I                                             -
     -                                      I                                             -
     -                                      I                                             -
     -                                      I                                             -
 80  -                                      I                                             -  80
     -                                      I                                             -
     -                                      I                                             -
     -                                      I                                             -
     -         *                            I                     *                       -
 70  -  ---   ---   ---   ---   -*-   ---   I  ---   ---   ---   ---   ---   ---   ---    -  70
     -   *                                  I                                             -
     -                     *                I                                             -
     -                                      I                                             -
     -                                      I                                             -
 60  -               *                      I                                             -  60
     -                                      I                                             -
     -                                      I                                             -
     -                                 *    I                                       *     -
     -                                      I                                             -
 50  -  ---   ---   ---   ---   ---   ---   I  -*-   -*-   ---   ---   ---   ---   ---    -  50
     -                                      I                                             -
     -                                      I                                 *           -
     -                                      I                                             -
     -                                      I                                             -
 40  -                                      I                                             -  40
     -                                      I                           *                 -
     -                                      I                                             -
     -                                      I                                             -
     -                                      I               *                             -
 30  -                                      I                                             -  30
        D     D1    DEP   IV    D-O   D-S      Si    St    Hy1   Pd4A  Mf6   Si2   I
Raw     32    17    12    14    20    12       29    20    0     11    3     3     14
Tscore  69    73    61    66    71    54       50    51    33    73    38    46    55
```

D - Depression
D1 - Subjective Depression
DEP - Depression
TSC-IV - Depression
D-O - Depression-Obvious
D-S - Depression-Subtle

Si - Social Introversion
St - Social Status
Hy1 - Denial of Social Anxiety
Pd4A - Social Alienation
Mf6 - Socially Retiring
Si2 - Discomfort With Others
TSC-I - Introversion

```
              Anxiety-Obsession                      Mania-Energy Level

      Pt     A    MAS    D5   PHO   VII   CPS    Ma    D2   Ma2   HYP   Ma-O Ma-S
100 -                                         I                                  - 10
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
 90 -                                         I                                  - 90
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
 80 -                                         I                                  - 80
    -                                         I                                  -
    -  *                                      I                                  -
    -                                         I                                  -
    -                                         I                                  -
 70 - ---   -*-   ---   -*-   ---   ---   --- I ---   ---   ---   ---   ---   --- - 70
    -              *                 *        I                                  -
    -                                         I                                  -
    -                                         I        *                         -
    -                                         I                    *     *       -
 60 -                                         I  *                               - 60
    -                                         I              *                   -
    -                                         I                                  -
    -                          *              I                                  -
    -                                      *  I                                  -
 50 - ---   ---   ---   ---   ---   ---   --- I ---   ---   ---   ---   ---   -*- - 50
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
 40 -                                         I                                  - 40
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
    -                                         I                                  -
 30 -                                         I                                  - 30
      Pt     A    MAS    D5   PHO   VII   CPS    Ma    D2   Ma2   HYP   Ma-O Ma-S
Raw   29    27     30    6     12    21    8     18    9     6     16    9     9
Tscore 76   70     68    70    55    68    52    60    64    59    62    63    50

      Pt - Psychasthenia
      A - Anxiety
      MAS - Manifest Arxiety
      D5 - Brooding
      PHO - Phobias
      TSC-VII - Tension
      CPS - Compulsive

      Ma - Hypomania
      D2 - Psychomotor Retardation
      Ma2 - Psychomotor Acceleration
      HYP - Hypomania
      Ma-O - Hypomania-Obvious
      Ma-S - Hypomania-Subtle
```

```
            Psychoticism            Hostility & Anger    Family Problems
        Sc  Sc3  PSY   VI  STY    Do  O-H  HOS   AH   Ho   Pd1  FAM
 100 -                         I                         I           - 100
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
  90 -                         I                         I           -  90
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
  80 -            *            I                         I           -  80
     -  *                      I                         I           -
     -                      *  I                         I           -
     -                         I                         I  *        -
     -                         I                         I           -
  70 - ---  ---  ---  -*-  --- I ---  ---  ---  ---  --- I ---  ---  -  70
     -                         I            *         *  I           -
     -                         I                         I           -
     -       *                 I                         I           -
     -                         I                         I       *   -
  60 -                         I                         I           -  60
     -                         I  *                      I           -
     -                         I                         I           -
     -                         I                 *       I           -
     -                         I                         I           -
  50 - ---  ---  ---  ---  --- I ---  -*-  ---  ---  --- I ---  ---  -  50
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
  40 -                         I                         I           -  40
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
     -                         I                         I           -
  30 -                         I                         I           -  30
        Sc  Sc3  PSY   VI  STY    Do  O-H  HOS   AH   Ho   Pd1  FAM
Raw     31    5   20   14   22    19   15   14    4   18     6    7
Tscore  78   65   81   70   77    58   51   68   55   69    75   62
```

Sc - Schizophrenism
Sc3 - Bizarre Sensory Experiences
PSY - Psychoticism
TSC-VI - Autism
STY - Schizotypal
Do - Dominance

O-H - Overcontrolled Hostility
HOS - Manifest Hostility
AH - Acting-out Hostility
Ho - Hostility
Pd1 - Familial Discord
FAM - Family Problems

719222 Intelus

UNIVERSITY OF PITTSBURGH MEDICAL CENTER

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

PSYCHIATRIC EVALUATION FORM

NAME: [redacted]

MEDICAL RECORD #: [redacted]

EVALUATION SETTING: BAC

DATE: 09/11/95

PATIENT IDENTIFICATION

Is this patient a twin? __x__ NO ____ YES

The patient is a single, employed, 26-year-old, white woman.

REASON FOR REFERRAL

The patient is requesting help with a mood disorder. She has a long history of manic depressive illness and wants to be seen for ongoing therapy and medication management.

HISTORY OF PRESENT ILLNESS

The patient reports that during the summer, she experienced a three month episode of Major Depression. She reported depressed mood, suicidal ideation, decreased energy and concentration, sleep and appetite disturbance, poor concentration, and feelings of hopelessness. She reports that within the last two weeks or so, that she is coming out of this Major Depressive Episode, but feels like she needs continued treatment.

The patient currently denies any symptoms of mania or hypomania, obsessions and compulsions, anxiety, substance abuse, and other compulsive behaviors. She also denies current suicidal ideation or homicidal ideation or plans.

PAST PSYCHIATRIC HISTORY (IF ANY)

The patient reports that she has a history of being treated in a Dual Diagnosis Inpatient Unit for three weeks in 1989 for Severe Major Depression and Alcoholism. She reports after this treatment program, she followed up with outpatient care and participated in AA Meetings. The patient also reports that in 1993, she was treated at Braddock Mental Health Center and saw a therapist and psychiatrist several times for "mood swings." She reports her diagnosis was Manic Depressive Illness and that she was placed on lithium. The patient reports that since taking lithium back n 1993, her moods have been fairly stable with the exception of the recent episode this summer of Major Depression. She reports taking lithium as prescribed. The patient reports that she moved out of the catchment area for Braddock Mental Health Center and received her lithium from a family physician for the past two years.

The patient reports that during her childhood, from ages ten to thirteen and ages fifteen to about fifteen and one-half, she had fairly serious obsessive thinking and compulsive rituals. These involved seeing herself as bad and feeling that she had to repeatedly rub germs off of her hands or bad things would happen to other people. She reports these obsessions and compulsions left her at about age fifteen and one-half. The patient also reports that as a young teenager from ages 13 to 17, she suffered from Anorexia Nervosa. She reports starving herself, but denies any use of diuretics, laxatives, or excessive exercising. She reports that she stopped the anorectic behavior when she started abusing alcohol at approximately the age of 17.

1690

SB 9.22.95

NAME: [redacted]

MR#: [redacted]
DATE: 09/11/95

PAST TREATMENT:

The patient reports that she had an eight month period of AA and NA involvement in 1989 and 1990. She was involved in the 12-Step Program and had a sponsor. She reports that "it was too much like a cult." She reports back in the 1989 and 1990 period when her drinking was excessive, she did see herself as an alcoholic, but she does not see herself as an alcoholic at the present time. She denies any episodes of excessive alcohol use in the past year and one-half.

SUICIDAL IDEATION AND BEHAVIOR

___ NO _x_ YES (Explain below)

Past

The patient reports that she had thoughts of cutting herself this past summer, but did not follow through with anything.

Current

She denies any current suicidality.

AGGRESSIVE IDEATION AND BEHAVIOR

___ NO ___ YES (Explain below)

Past

The patient denies.

Current

The patient denies.

HISTORY OF DRUG AND ALCOHOL ABUSE

___ NO _X_ YES (Explain below)

Past

She reports a period of alcohol abuse dating back from the late 1980s to about 1990. She reports frequent episodes of intoxication up to three to four times a week, consuming large amounts of alcohol, experiencing occasional black-outs, an increase in tolerance and psychosocial problems. She reports that as a result of her excessive drinking, she was more prone to physical problems such as missing class due to a variety of illnesses, feeling run-down, and that she has had interpersonal conflict as a result of her drinking. The patient also reports inappropriate sexual behavior, both when in a manic phase and during periods of excessive alcohol consumption. The patient also reports a six month history of almost daily use of marijuana back in 1990, but denies any use since that time. She denies any use of opiates, hallucinogens, cocaine or stimulants, sedatives, or inhalants.

Current

The patient reports that she drinks one to two beers a month and has not used in the past two weeks. She reports that she has not been drunk for the past year and one-half.

NAME: [redacted]

MR#: [redacted]
DATE: 09/11/95

FUNCTIONING LEVELS (AXIS V)

Past GAF Score: 70
Highest level of functioning in the past year for at least a few months

Current GAF Score: 60
Level of functioning at time of assessment

PERSONAL, DEVELOPMENTAL AND SOCIAL HISTORY

The patient reports that she is the oldest of two children. Her parents are described in good health. Her father is 65 and has apparently recovered from a heart attack several years ago. Her mother is 52. Both live in Pennsylvania. The patient reports that she is fairly close to her parents and does not feel particularly close to her 22-year-old brother who is attending a Masters Program in Alabama. The patient reports that she was a high honor student in both college and high school. She reports main difficulty in high school revolving around difficulty keeping friends and feeling like an outcast. However, she reports improved interpersonal relationships while in college. She graduated in 1990 with a degree in music from Indiana University of Pennsylvania. Since that time, she has held two jobs in the computer field; one as a data entry clerk and more recently, word processing.

SOCIAL STRESSORS (AXIS IV)
Description of Recent Stressors

Recent stressor is change in job about four months ago.

Overall Stressor Severity

___ NONE = 1 ___ MILD = 2 _x_ MODERATE = 3 ___ SEVERE = 4

___ EXTREME = 5 ___ CATASTROPHIC = 6 ___ UNSPECIFIED = 7

SOCIAL SUPPORTS

The patient reports that she has several friends. She is heterosexual. She reports her main avocation hobby evolves around composing and performing music. She describes herself as a fairly prolific song writer and is trying to produce music and have it published. She reports that music takes up most of the time aside from working. She currently lives on her own. She supports herself with a $20,000. She grew up a Catholic, but currently is active in the First Unitarian Church. She is active in the choir and reports that religion is very important to her.

MEDICAL HISTORY AND PHYSICAL EXAMINATION
Active Medical Problems

The patient denies.

Current Medications (Include over the counter medications).

1. Lithium 900 mg a day.
2. She is on sulfa, an antibiotic 1,000 mg daily. She has been on this for two months for a skin condition.

Past Medical History

None reported.

NAME: [redacted]

MR#: [redacted]
DATE: 09/11/95

Review of Systems

ALLERGIES

_x_ NO ___ YES (If YES, list below)

NONALLERGIC ADVERSE DRUG REACTIONS

___ NO _x_ YES

ONE SPECIFIC ANTIBIOTIC- ________________.

Physical Exam

Vital Signs:

(Sitting) BP	______	Pulse	______	Temp	______
(Lying) BP	______	Pulse	______	R.R.	______
(Standing) BP	______	Pulse	______		

Current Health Provider

Dr. Offerman in Point Breeze.

SIGNIFICANT FAMILY MEDICAL AND PSYCHIATRIC HISTORY

The patient reports a paternal uncle had depressive illness, a paternal cousin had alcoholism and compulsive gambling disorder, a maternal great-aunt had alcoholism, and a paternal aunt had cancer.

IMPACT OF PATIENT'S ILLNESS ON FAMILY AND OTHER SUPPORT SYSTEMS

She reports minimal adverse impact on her family during the active phase of her illness, stating that because she lived away from them and had limited contact, they did not know the degree to which she suffered. She did say, however, that they were shocked and upset when they learned of her psychiatric condition. She does report, several years ago, during episodes of alcohol abuse, that interpersonal relationships became problematic.

MENTAL STATUS EXAMINATION

Appearance and General Behavior

The patient was dressed casually and was cooperative during the interview.

Mood and Affect

Mood and affect were within normal limits with no current evidence of depression, anxiety or hypomania.

Rate and Pattern of Speech and Thought

Within normal limits with no current evidence of loose associations.

Content of Speech and Thought

Within normal limits, and she was able to focus on questions in the interview. She denied obsessions, ideas of reference, or delusions.

Perception

The patient denied any kind of hallucinations.

Cognitive Functions

The patient was oriented times three with memory intact. She made one mistake in subtracting 7's from 100. Judgment fair. Ability to abstract is intact.

Insight

Fair to good. She knows that despite having come out of a recent episode of depression, that she needs to stay closely involved in treatment.

PATIENT STRENGTHS

1. She is full-time employed.
2. Articulate, willing to comply with medication management, and willing to attend psychotherapy sessions as needed.

NAME: [redacted]

MR#: [redacted]
DATE: 09/11/95

SYMPTOM INVENTORY

___01 Impaired Sensorium
___02 Impaired Orientation and/or Memory
___03 Poor Concentration, Distractibility
___04 Self-Neglect
___05 Bizarre Behavior
___06 Self-Abusive Behavior
___07 Delusions
___08 Hallucinations
___09 Thought Process Disorganization
___10 Elation, Expansiveness
___11 Hyperactivity, Agitation
___12 Psychomotor Retardation
___13 Sleep Disturbance
___14 Eating Disturbance
_x_15 Sadness, Dysphoria
___16 Suicidal Indicators
___17 Anxiety
___18 Phobias
___19 Obsession/Compulsions
___20 Somatization, Hypochondriasis
___21 Dissociative Symptoms
___22 Sexual Problems
___23 Alcohol Abuse
___24 Abuse of Other Drugs
___25 Homicidality, Assaultiveness
___26 Antisocial Behavior
___27 Impulsivity
___28 Social Withdrawal
___29 Unstable, Dramatic Behavior
___30 Overdependent, Hypersensitive Behavior
___31 None of the Above

ASSESSMENT SUMMARY

The patient is a 26-year-old, single, white, employed female who comes to us for ongoing help with a long-standing bipolar disorder. Although her mania has been under control for the past several years, she recently experienced a three month episode of Severe Major Depression, which just recently ended a little over two weeks ago. During that time, the patient reports that she was compliant with her lithium. Although the patient presents with a past history of alcohol dependence, she currently does not present any symptoms indicating that she meets criteria for Alcohol Abuse or Dependence at this time. She denies excessive use of alcohol in the past year and one-half and drinks occasionally; one to two beers a month.

RECOMMENDATIONS FOR FURTHER EVALUATION
Additional History

NAME: [redacted]

MR#: [redacted]
DATE: 09/11/95

Diagnostic Assessments

TREATMENT RECOMMENDATIONS

1. Ongoing pharmacotherapy.
2. Supportive psychotherapy.
3. Encourage the patient to rethink about going to AA Meetings and focusing on abstinence given her past history of Alcoholism and Mood Disorder.

NAME: [redacted]

MR#: [redacted]
DATE: 09/11/95

DSM-IV MULTIAXIAL DIAGNOSTIC FORMULATION

Code S

I. CLINICAL PSYCHIATRIC SYNDROMES AND V CODES S=Severity

1. BIPOLAR I, MOST RECENT EPISODE, DEPRESSED. 296.52

Alternative diagnoses to be considered
1.

II. DEVELOPMENTAL AND PERSONALITY DISORDERS

1. DEFERRED. 799.9

Alternative diagnoses to be considered
1.

III. PHYSICAL DISORDERS AND CONDITIONS

1. V71.09

Alternative diagnoses to be considered
1.

DISPOSITION

Name of Program or Facility	Admit/Appt. Date
Center for Chemical Dependency and Psychiatric Services.	09/11/95

Were referrals and recommendations accepted by patient/family?
___ NO x YES (If NO, Explain below)

Legal Status After Evaluation: Voluntary.

EVALUATORS

Clinician or Resident	1	D. B M.S.W.	6698 CODE	09/12/95 DATE
Clinician or Resident	2		CODE	DATE
Faculty Physician	3	H M . M.D.	7233 CODE	09/12/95 DATE

DD/dlq
D 09/12/95
T 09/12/95 (17.12)
3295

PSYCHIATRIC EVALUATION FORM
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UNIVERSITY OF PITTSBURGH MEDICAL CENTER

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

ADULT & GERIATRIC PSYCHIATRY DIVISIONS
PSYCHOSOCIAL ASSESSMENT

NAME:	[redacted]
MEDICAL RECORD #:	[redacted]
DATE OF ADMISSION:	11/06/95
ADDRESS:	[redacted]
TELEPHONE #:	[redacted]
COMMITMENT STATUS:	201 Voluntary Commitment
BSU:	Turtle Creek
INPATIENT UNIT:	13th Floor
INPATIENT SOCIAL WORKER:	B. P , L.S.W.

SOURCE OF INFORMATION:

Information was gathered from the patient, the patient's mother, and WPIC records.

REASON FOR ADMISSION (including patient and/or family perceptions and expectations of treatment):

The patient reports she felt like her body was "full of lead." She reports having suicidal thoughts and had a fear that she would act on them.

SIGNIFICANT FAMILY MEMBERS & SIGNIFICANT OTHERS (name/relationship/age if known; other persons residing in the household):

[redacted]e patient's parents, [redacted]
[redacted] the patient's brother, age 22.

RELEVANT CUSTODY/GUARDIANSHIP ISSUES:

There are no relevant custody or guardianship issues.

CURRENT PROVIDERS/INVOLVED AGENCIES (including date of involvement & telephone):

The patient has had approximately six sessions with Dennis Daley at CPCDS; 383-1261.

RELEVANT FAMILY INFORMATION (historical and current):

The patient reports she grew up in Wilkes-Barre, a small town in Pennsylvania. The patient reports she did not like it and did not like anybody in the town. The patient reports always feeling that she did not belong, which made it difficult for her to make friends. The patient has one younger brother, [redacted], age 22. The patient reports she had a very active fantasy life and had many imaginary friends between the ages of three and seven. She reports her mother said she was too old to have imaginary friends, so she began talking her to her dolls rather than imaginary friends, which was more acceptable to her mother. In addition, the patient began writing out screen plays at age nine to channel her internal fantasy life. The patient sees her creativity as both a "gift and curse."

The patient reports her mother was at home when she was little. At 12, she reports her mother went to work as a prison librarian. The patient reports her father was a high school history teacher and athletic director. The patient reports around age 13, she became obsessed with food and dieting. During high school, she reports having only one or two friends at a time and denies that these relationships were very close. The patient remained obsessed with food through her high school years. The patient recalls her father calling her "fat." In college, the patient began drinking and feels she was a problem drinker during her college years. After college, the patient moved to Pittsburgh. The patient reports she has a few close friends but still feels as though she does not really belong.

The patient described her mother as "touchy-feely." She reports her mother was very intelligent and self-educated. The patient describes her father as "mean-witted but generous." She reports he is "Type A" and feels he ordered her mother around. The patient feels that her parents are a "strange couple."

CHILDREN OF PATIENT AT POTENTIAL RISK FOR THE DEVELOPMENT OF PSYCHIATRIC DISORDERS (list name & age, note if previously identified and receiving treatment, or if high-risk screening may be indicated):

The patient has no children.

PSYCHOSOCIAL ISSUES:

A. Living Situation/Housing

The patient lives in her own apartment.

B. Recent Lifestyle Events/Losses

The patient does not identify any specific lifestyle changes or losses. The patient does report that she feels very unsatisfied and unhappy in her work.

C. Coping Style & Problem-Solving Abilities

The patient in the past has used alcohol and eating as a coping style. More recently, the patient attempts to talk with friends and has enlisted the help of a counselor. However, the patient has a difficult time expressing her thoughts and feelings.

D. Financial

The patient supports herself from her full-time job.

E. Employment

The patient works full-time as a word processor.

F. Cultural/Religious Issues

The patient denies any cultural/religious issues pertinent to treatment.

G. Legal Involvement

The patient denies any legal history.

H. Disabilities

The patient denies any disabilities.

I. Social Support

The patient has several close friends that she identifies as social support.

J. Marital and Relationship Problems

The patient is single.

K. Child Care and Parenting

The patient has no children.

L. Other

No other psychosocial issues were identified.

PATIENT & FAMILY STRENGTHS:

The patient is very intelligent. The patient is very creative in both writing and music. The patient is motivated for treatment. The patient's parents express concern for the patient and a willingness to learn more about her illness.

SOCIAL WORK INTERVENTION PLAN:

X Individual Meetings
X Family Meetings with Patient
___ Family Meetings without Patient
___ Housing
X Family Phone Contact
X Patient Groups
X Family Psychoed/ Support Group
___ ICM/RC Referral
___ Children's Group
___ Parenting Skills
X Contact with Outpatient Treatment Team
___ Referral for More Restrictive Setting (specify):
___ Other:

FOCUS OF INTERVENTIONS:

X Psychoeducational
X Supportive
___ Specialized Skill Training
X Psychosocial Stressors
___ Family Issues
___ Parenting Issues
___ Interpersonal Conflicts
___ Relationship Issues
___ Caregiving
X Reality Orientation
X Aftercare Planning

AFTERCARE PLAN:

A. **Living Arrangement(s)**

The patient will return to her apartment.

B. **Treatment Recommendations** (including community resources and supports):

The patient will return to CPCDS to be followed by Dennis Daley.

C. **Financial Arrangement**

The patient will continue to work full-time.

D. **Patient/Family Reactions to Aftercare Plan**

The patient and family are in favor of the aftercare plan.

E. **Patient/Family Education** (significant issues which should continue to be addressed in follow-up care):

The patient and family need continued education and support around the patient's illness and need for ongoing appropriate treatment.

B P LSW
B P L.S.W.

BP/eab
D: 11/13/95
T: 11/14/95 (01:05)
5527

UNIVERSITY OF PITTSBURGH MEDICAL CENTER

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

DISCHARGE SUMMARY FORM

NAME: [redacted]	MEDICAL RECORD #: [redacted]
ADMISSION DATE: 11/06/95	PROGRAM: 13th Floor
DISCHARGE DATE: 11/27/95	PROGRAM: 13th Floor

PATIENT IDENTIFICATION

The patient is a 26-year-old, single, white female admitted on a 201 after being referred by therapist, D D at CPCDS; patient experiencing worsening depressive symptoms and suicidal ideation. The patient was accompanied to the Diagnostic Evaluation Center by a friend.

REASON FOR REFERRAL

PSYCHIATRIC HISTORY

The patient is known to Western Psychiatric Institute and Clinic through outpatient treatment. She also has been hospitalized in the past. She also has received psychiatric treatment in the past through Braddock Medical Center. The patient reports an onset of periods of depression and mania since teenage years. Her first psychiatric hospitalization was in 1989 at the age of 20. The patient reports being depressed at this time and also having difficulty with using alcohol and cannabis. She reports being treated with Prozac at this time and initially experiencing relief from depression; however, she reports developing mania after discharge from the hospital and, subsequently, stopped taking the Prozac. The patient reports developing multiple cycles of depression lasting approximately two months, alternating with periods of euthymia then periods of mania which lasted approximately two weeks. The patient estimates having had at least 10 such cycles in the period from 1988 up until the time she started taking Lithium in 1993. The patient endorses euphoria, increased energy, decreased sleep, increased sense of self-confidence and socialization, sexual promiscuity and increased drug use during her manic periods; however, the patient states that since taking Lithium she has not experienced a manic episode. The patient, however, endorses possible episodes of mixed symptoms with racing thoughts, internal sense of agitation, mood lability. The patient reports no other treatment with antidepressants or other psychiatric medications in the past. The patient also reports onset in her teens of obsessive behaviors including hand washing, checking and counting. She also reports that she developed Anorexia Nervosa as a teenager. The patient currently denies restricting food intake but does admit to preoccupation with food and her weight. The patient did not endorse above symptoms, nor were they evidenced during this hospitalization.

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NAME: [redacted]
MR#: [redacted]

ADMISSION DATE: 11/06/95
DISCHARGE DATE: 11/27/95

TREATMENT COURSE
Treatment Modalities

X Individual therapy	___ Neuroleptics	X Antiparkinsonian medication
X Group therapy	X Minor tranquilizers	___ Anticonvulsants
X Family therapy	X Antidepressants	___ Other medication
___ Specific behavior techniques	X Lithium	___ ECT
___ Vocational training	___ Stimulants	___ Other modalities

Suicidal or aggressive ideation and behavior during this treatment episode?

___ NO X YES (Explain below)

During initial week of hospitalization, the patient had persistent suicidal ideation and morbid preoccupation with death; however, no plan or attempts to harm self while in the hospital and towards the end of discharge, the patient's suicidal ideation remitted.

Did patient cooperate with overall treatment during this treatment episode?

___ NO X YES (Explain below)

The patient was very receptive to treatment. She participated in all forms of therapy offered.

Rating of improvement in patient's condition during this treatment episode.

___ Marked Improvement	X Moderate Improvement	___ Slight Improvement
___ No Change	___ Worsening	___ Unspecified

NARRATIVE SUMMARY OF TREATMENT COURSE

The patient is a 26-year-old, single, white female with a history of Bipolar Disorder, admitted after worsening of depressive symptoms including suicidal ideation, also some bizarre thoughts regarding death and episodes of depersonalization and auditory hallucinations, initially presenting with catatonic features of poverty of speech and movement despite racing thoughts. This resolved with routine Ativan dose. This Ativan dose was slowly tapered down during admission as the patient improved and the patient will not be discharged with the Ativan as part of her medication regime. Also, Risperdal was added which the patient has tolerated her Lithium was increased and level of 1.2 obtained on 11/18/95. On 11/26/95 an additional Lithium level was obtained at 1.36 and Lithium was decreased at 600 mg b.i.d. The treatment team's recommendation is that an additional Lithium level be obtained on 11/30/95. During the initial week of hospitalization, the patient's symptoms persisted with extreme mood lability, preoccupation with death and morbid theme, suicidal ideation and an inability to guarantee her safety outside of the hospital, internal sense of agitation, racing scattered thoughts and bizarre depersonalization experiences including the sense that she was outsider her body

NAME: [redacted]
MR#:

ADMISSION DATE: 11/06/95
DISCHARGE DATE: 11/27/95

at times. Her mood eventually stabilized and thought processes cleared to the point where the patient was more socially engaged, able to participate more fulling in milieu treatment and felt in control of her thoughts. Her suicidal ideation and morbid preoccupation remitted. Her sleep, activity level and appetite improved. The patient was able to take a successful pass to home for the holiday; however, she has complained of some side effects, predominantly visual difficulty and some sedation; her Lithium and Risperdal doses were decreased and the treatment team's recommendation is that she be closely monitored for return of manic or mixed symptoms and also psychotic symptoms. The patient also had episodes of difficulty swallowing, likely due to glossal dystonia; the patient given p.r.n. Cogentin for this with good results.

MENTAL STATUS AT TIME OF DISCHARGE

Appearance and General Behavior

The patient presented as pleasant and cooperative.

Mood and Affect

Her affect was somewhat blunted but no lability noted. Her mood was "good" and "stable."

Rate and Pattern of Speech and Thought

Speech slow and halting but no blocking noted; no circumstantiality or tangentiality.

Content of Speech and Thought

Content focused on making preparations for discharge. Denies current psychotic symptoms. No evidence of paranoid or delusional ideation.

Perception

No evidence of perceptual anomalies and denies episodes of depersonalization or derealization at this time. Denies suicidal, self-harmful, aggressive or homicidal ideation.

Cognitive Functions

Oriented times three. Cognitive functions appear intact. Judgement improved, able to state safety plan for discharge.

Insight

Insight into need for continued treatment good.

NAME: [redacted]
MR#:

ADMISSION DATE: 11/06/95
DISCHARGE DATE: 11/27/95

DSM-IV MULTIAXIAL DIAGNOSTIC FORMULATION

Code S

I. **CLINICAL PSYCHIATRIC SYNDROMES AND V CODES** S=Severity

1. BIPOLAR I DISORDER, MOST RECENT EPISODE DEPRESSED, SEVERE WITH MOOD CONGRUENT PSYCHOTIC FEATURES, WITH RAPID CYCLING AND WITH CATATONIC FEATURES. 296.54
2. ALCOHOL DEPENDENCE IN FULL REMISSION. 303.90
3. CANNABIS DEPENDENCE IN FULL REMISSION. 304.30
4. OBSESSIVE COMPULSIVE DISORDER BY HISTORY. 300.3
5. ANOREXIA NERVOSA BY REPORT. 307.1

Alternative diagnoses to be considered
1 ______

II. **DEVELOPMENTAL AND PERSONALITY DISORDERS**

1. PERSONALITY DISORDER, NOT OTHERWISE SPECIFIED. 301.9

Alternative diagnoses to be considered
1. PULE OUT SCHIZOTYPAL PERSONALITY DISORDER. 301.22
2. PULE OUT BORDERLINE PERSONALITY DISORDER TRAITS. –

III. **PHYSICAL DISORDERS AND CONDITIONS**

1. ACNE. 706.1

Alternative diagnoses to be considered
1. ______

IV. **OVERALL STRESSOR SEVERITY**

____ NONE - 1 ____ MILD - 2 __X__ MODERATE - 3 ____ SEVERE - 4
____ EXTREME - 5 ____ CATASTROPHIC - 6 ____ UNSPECIFIED - 7

V. **FUNCTIONING LEVELS (AXIS V)**

A. Past GAF Score: 30

B. Current GAF Score: 80

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DISCHARGE SUMMARY FORM
CHART COPY

NAME: [redacted]
MR#: [redacted]

ADMISSION DATE: 11/06/95
DISCHARGE DATE: 11/27/95

DISPOSITION

A. Rationale for discharge:
_X_ Treatment objective achieved ___ AMA
___ Transfer to state hospital ___ Other

B. Referrals:

1. The patient will be seen by Dennis Daley at CPCDS and followed also by Dr. Salloum through CPCDS.

C. Medications prescribed at discharge

Name of Medication	Schedule	Amount
1. Lithium carbonate	600 mg p.o. b.i.d.	
2. Risperdal	1 mg p.o. at h.s.	
3. Cogentin	1 mg p.o. p.r.n. extrapyramidal symptoms/difficulty swallowing q. 6h maximum two times a day.	———
4. Retin A cream	Use topically to face.	Given at time of discharge

D. Other instructions given to the patient (e.g., physical activity, medication, and diet)

THE PATIENT IS ALLERGIC TO ILOSONE (ERYTHROMYCIN). HER REACTION IS ANAPHYLAXIS. Diet and activity as tolerated.

E. Further treatment recommendations

___ None
___ Pharmacotherapy
___ Individual therapy
___ Vocational training
___ Group therapy
___ Remedial education
___ Family therapy
_X_ *Other

* The patient is not to drive at this time due to blurry vision. To be re-evaluated by treatment team after discharge. Also recommendations are that the patient obtains a Lithium level on 11/30/95 and she was given a prescription for this.

F. Were referrals and recommendations accepted by patient/family?

___ NO _X_ YES (if NO, explain)

EVALUATORS

Physician or Resident 1		9523 CODE	11/28/95 DATE
Physician or Resident 2		7806 CODE	11/28/95 DATE
[illegible] Physician 3		7602 CODE	11/28/95 DATE

11/28/95
[illegible] (13:32)

DISCHARGE SUMMARY FORM
CHART COPY

CASE STUDY

May 24, 1996

Background and Referral Information

The patient, , is a 45 year old, white, single male admitted to WPIC initially in 1980. The patient resides with his parents, and , in the section of Pittsburgh, Pennsylvania. Mr. presents with a long history of depressive symptoms accompanied by debilitating, generalized, somatic complaints of weakness and pain. These symptoms include decreased sleep, decreased appetite with at least a 50 - pound weight loss in 1980, depressed mood, anhedonia, increased social insolation, anergia, hopelessness, decreased activities of daily living, increased somatic complaints, delusions, and suicidal ideation without a plan. The patient has been diagnosed as follows: Axis I: Major Depression with Psychotic Features, severe and recurrent, Axis II: Schizotypal Personality Disorder, Axis III: Status Post Electroconvulsive Therapy and Clubbed Feet, and the Axis V: is 60. Patient was referred to PRAS on 03\01\96 for vocational counseling, help with career selection and getting job ready by his therapist from CCP, Nina Bridenbaugh. Initial session with Rosyvee Guzmán under the supervision of Michelle Geckle, M.Ed., CRC was April 09, 1996. In this session patient expressed that he needs to "start something" in his life, because his experience is limited to working with his father in a dry cleaning business. Patient expressed a vocational interest in health care area, but he does not know what specific area he wants.

Psychiatric History

In August, 1980, at the age 29, the patient began to experience depressive symptoms, including decreased sleep, appetite disturbance, increased agitation and a feeling of depression. Patient related that in September, 1980, he moved in with his parents because he had financial problems. In this month, his parents sent Mr. to a private psychiatrist, who started the patient on Sinequan. Patient related that this medication did not improve the depression. Then the patient became further depressed and began complaining of hallucinations. He was hospitalized at Western Pennsylvania Hospital, but, he left the hospital AMA after four days. Then, the patient was admitted to WPIC from in 10\09\80 - 12\18\80. He related that at this time, he felt very weak, and he did not have energy to do anything. He also started to experience other significant symptoms: anhedonia, lack of energy, hopelessness, very poor concentration, very impaired sleep, decreased appetite, increased social withdrawal and intermittent suicidal ideation without a specific plan and delusions. During hospitalization he was treated for depression at that time with ECT treatments. He did not comply with recommended out patient treatment and returned to his parents home. Reportedly, from 1981 until his second admission to WPIC on 11\01\93 at the age 42, remained significantly depressed and quite dysfunctional. In 1993 's father gave him an ultimatum to "get his act together" or he would have committed to the hospital. He described as a "human vegetable". As M continued to do nothing but lie in bed all day, his father brought him to WPIC. He was hospitalized from 11\01\93 until 01\07\94. It was decided that since the patient had a severely retarded, withdrawn depression, and psychotic symptoms, specifically somatic delusions, ECT was begun. He had a course of 16 ECT treatments, during which he had significant confusion which did resolve *back to good cognitive functioning. He did have marked improvement in depressive symptoms. He was also treated with Zoloft 50 mg. He was discharged to CCP for individual therapy and medication maintenance, with which he has been compliant. He attended group therapy for approximately seven months as well. The patient received SSI in early 1995. At this moment, the patient denies having ideas of reference, auditory or visual hallucinations or feelings that his thoughts or actions are being controlled. Patient related that all he does during the day is listen to talk shows on the radio, eat, sleep and look at television.*

Family History and Background Information

The patient has two brothers and one sister, and he is the oldest. His mother, is age 65 and a housewife. The patient's mother has been diagnosed with Bipolar Disorder and she received ECT treatment as a result of post-partum depression following the birth of her last child. The patient also has a brother, who has schizophrenia and who lives in a group home in The patient's younger brother lives in California, and his sister lives in New Jersey. The patient's father is age 67, and is now retired. He owned a dry cleaning business which he sold in 1993. He has hypertension. The patient's paternal grandmother has a history of depression, and she died due to colon cancer. The patient's maternal grandmother had emphysema.

Social Supports

The patient's main supports are his parents, particularly his father.

Developmental History

The patient is the oldest of four children, having two younger brothers and one sister. The patient was born and raised in Pittsburgh. The patient's mother reportedly had a normal pregnancy and delivery without complications, but the patient had a congenital deformity, club feet. As a child, the patient had to wear shoes with a bar in between when he went to bed, causing difficulty in sleeping. At age 18 months, the patient received physical therapy in D.T. Watson Home for Crippled Children. During this time, the patient's mother was only allowed to visit on weekends. The patient's mother reported that when she would visit, was happy to see her, however, frequently cried. By age 3, had two operations for corrective surgery on his feet. At the age 5 1/2, started kindergarten without incident, and apparently he had a good adjustment to school. Patient reported that he completed the elementary school with A's- B's and C's. The patient's parents reported that had no behavioral problems, and they reported that 's major interest was reading. The patient reported that he rarely participated in any athletic events. The patient reported that he experienced considerable difficulty adjusting to Junior High School and High School, which were new settings for him. He graduated from High School in 1969, and attended the University of Pittsburgh. The patient received a college degree in 1973 in

Political Science. Then he worked in father's dry cleaning business. The patient's parents reported that did not show motivation or confidence to take on much responsibility in the business. Patient related that he felt bored and frustrated with his work at the family business but also locked confidence in himself. He tried working in his father's home remodeling business in , Pennsylvania, but found this unsatisfying also and returned to the dry cleaning business after two months. He was able to work until his first depression in 1980 but has been unable to maintain any employment since that time. He did volunteer work at Shadyside Hospital in Physical Therapy Department during the summer of 1995, and liked this. However when the PT student interns returned in September 1995, there was no longer a role for him. He was offered another volunteer position in a clerical capacity which he declined. He has had no vocational activity since this time.

Medical History/ Physical Health Problems

The patient has a congenital deformity, club feet and has had multiple surgeries for this condition. The patient is unable to be on his feet for long and now has traumatic arthritis. Patient reported that he has prescription glasses, but he said he does not like wearing them, except for driving. Patient appears over weight, which exacerbates the condition of his feet.

Test Observations

Patient expressed genuine interest in engaging in vocational and educational assessment. The patient appeared mildly anxious throughout testing sessions, but maintained excellent effort. Patient was most cooperative during the testing sessions. The patient had some difficulty sustaining concentration over lengthy (several hours) testing sessions. Patient appeared to fatigue easily, hence testing was administrated over four different days. During different tests in the visual area, patient appeared to be squinting his eyes because he does not like using glasses. Throughout testing he was aware of personal weaknesses (visual spatial, constructional) and able to joke slightly about these, e.g. on Block Design. His approach to task was slow, cautious and deliberate.

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

Patient Name: M Hospital No.: ________ Program: PRAS

DATE	PROB NO	PROBLEMS	GOALS AND MEASURABLE PERFORMANCES	METHODS	TARGET DATE	ATTAIN DATE
4-16-96	E1	M is uncertain regarding career goals and courses of action to take: a) employment experiences limited to dry cleaning business b) dissatisfaction with current job; desires to explore alternatives Strengths: • BA in Political Science • stable income • stable housing	Long Term Goal: M will have established and followed through on a plan of action to aid in determining specified vocational goal(s). Short Term Goals: 1. M will review previous educational and vocational experiences to aid in current planning. 2. M will explore pros/cons of high interest career options in the area of health care, including self-assessment (i.e., interest, resources, time) and educational resource materials. 3. M will utilize results of vocational assessment in career exploration. 4. M will begin to take classes in an area of interest related to defined career goal. 5. M considers volunteer work to aid in career decision making and determining work tolerance level.	PRAS clinicians, Rosyvee Guzmán, B.A., and Michelle Geckle, M.Ed., CRC, will provide on a weekly basis individual career counseling and guidance.		4-16-96

This written document does not constitute a legal contract guaranteeing or promising treatment outcomes.

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
TREATMENT PLAN

Patient Name: ____________________ Hospital No.: ____________ Program: ______________________

DATE	PROB NO	PROBLEMS	GOALS AND MEASURABLE PERFORMANCES	METHODS	TARGET DATE	ATTAIN DATE
			6. M will verify re-training program costs and financial aid sources (Pell, PHEAA, loans, work study), application forms and deadlines. 7. M will verify admission/acceptance criteria (i.e., prerequisites, transfer credits). 8. M will verify course registration process (advisor, nature of courses, course selection, credit hours, class time-schedule, deadlines).			

This written document does not constitute a legal contract guaranteeing or promising treatment outcomes.

✓

6-14-94

UNIVERSITY OF PITTSBURGH MEDICAL CENTER
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
3811 O'HARA STREET
PITTSBURGH, PA 15213

DIAGNOSTIC INFORMATION

Patient Name: M. DICKSON Number: 056167

Axis I:	Clinical Psychiatric Syndrome	Codes
1.	Major Depression w Psychotic Features, Severe, Recur.	296.34
2.		
Axis II:	Personality and Specific Developmental Disorders	
1.	Schizotypal Personality	301.22
2.		
Axis III:	Physical Disorders	
1.	Status Post Electroconvulsive Therapy	V 67.59
2.	Clubbed Feet	754.70

Axis V GAF 60

6/14/94 / Nina Bridenbaugh, LSW / NINA BRIDENBAUGH 1868
Date Primary Clinician Signature Please Print Name Clinician #

6/16/94 / Margaret FitzGerald / M. FITZGERALD-MALONE/ 7588
Date Physician of Record Signature Please Print Name Clinician #

Tname:DIAGNOSTIC.INF

1-11-94

CC

WPIC # ________

UNIVERSITY OF PITTSBURGH

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

DISCHARGE SUMMARY FORM

Name: ________ , ________

Admission Date: 11/01/93 Program: 10th Floor

Discharge Date: 01/07/94 Program: 10th Floor

PATIENT IDENTIFICATION

The patient is a 42-year-old, single, white male who lives with his parents. His family history is significant for a mother with Bipolar Disorder and a brother with Schizophrenia. The patient has a previous episode of Major Depression treated with ECT.

REASON FOR REFERRAL

The patient was admitted voluntarily at the urging of his parents because of his severe dysfunction for about 12 years and increasing depressive symptoms. He has, lately, been having extreme weight loss, retardation of functioning, and suicidal ideation. In addition, his major complaints are diffuse body pain and diffuse sense of heaviness in his limbs which he attributes to delusional beliefs.

PSYCHIATRIC HISTORY

The patient was previously admitted to Western Psychiatric Institute and Clinic in 1980. The patient says that he feels very weak recently and cannot muster the energy to do anything. He has an accompanying feeling that his arms and legs are heavy and that his entire body feels like a lead weight. In addition, the patient states that he is depressed and endorses feelings of significant anhedonia, lack of energy, hopelessness, very poor concentration, very impaired sleep, decreased appetite, increased social withdrawal, and intermittent suicidal ideation without a specific plan. He occasionally does consider cutting his wrists. He said that he has an overall bodily pain and weakness which prevents him from doing any physical activity. The patient was unable to specify how long the symptoms have been occurring, but it seems that they have been worsening over approximately three to four months. He states that a turning point for him was in 1989 when he held his breath several times to "cut the air off" because he was hyperventilating. He states that this has caused damage to his body and that the incidence was a precipitant to his recent symptoms. The patient's parents note that he has been doing very little daily functioning for approximately 10 years and that his depressive symptoms have been present since then but worsening over the last four to five months. The patient said that he had just enough strength to come into the hospital the night before and said that he has tried to treat his pain with Tylenol which did not work.

The patient denies having ideas of reference, auditory of visual hallucinations, or feelings that his thoughts or actions are being controlled. He does endorse occasionally that he feels that his thoughts are racing. He says that all he does during the day is listen to talk radio and eat meals and that he gets by just "breathing in and out." The patient said that he has lost about 50 pounds in the

NAME: WPIC #

last several months. He said that he has been extremely nervous and scared about his present condition and that he worries about his health but is not worried that he will die.

The patient was admitted previously at WPIC in 1980 for an apparent, similar depressive episode, treated with ECT with the possible complication of confusion versus hypomania. The patient's past history is also significant for clubbed feet. For details of social history, please see dictated Social History which is significant for previously good function through college as a political science major.

TREATMENT COURSE
Treatment Modalities

X Individual therapy
X Group therapy
___ Family therapy
___ Specific behavior techniques
___ Vocational training
___ Neuroleptics
___ Minor tranquilizers
X Antidepressants
___ Lithium
___ Stimulants
___ Antiparkinsonian med.
___ Anticonvulsants
___ Other medication
X ECT
X Other modalities

Antipsychotic therapy.

Suicidal or aggressive ideation and behavior during this treatment episode? X NO ___ YES (Explain below)

The patient had vague suicidal ideas but no suicidal behavior or aggressive behavior during hospitalization.

Did patient cooperate with overall treatment during this treatment episode? ___ NO X YES (Explain below)

The patient was cooperative during the hospitalization.

Rating of improvement in patient's condition during this treatment episode.
X Marked Improvement ___ Moderate Improvement ___ Slight Improvement ___ No Change ___ Worsening ___ Unspecif

NARRATIVE SUMMARY OF TREATMENT COURSE

PROBLEM #1. Major Depression, Severe With Psychotic Symptoms, Recurrent.

It was decided that since the patient had a severely retarded, withdrawn depression, and psychotic symptoms, specifically somatic delusions, we would begin treatment with electroconvulsive therapy. The patient agreed to ECT as did the family, and he had a course of 16 ECT treatments, initially with six unilateral changing to 10 bilateral treatments. During the course of bilateral ECT, the patient did have significant confusion on each day of the ECT which did resolve significantly back to his baseline mental status of being well oriented and alert with good cognitive functioning.

The patient's workup including EEG, chest x-ray, spine films, and EKG were normal except for an incomplete bundle branch block on EKG. Overall, the patient tolerated ECT very well and did have marked improvement with the electroconvulsive therapy. There was a brief period after treatment 12 in which we held the ECT treatments to observe the patient's condition due to confusion, and he had an acute worsening of depressive symptoms, hopelessness and somatic delusions resulting in our decision to continue with 16 treatments. The last four treatments were spaced out over at least three to four days between each treatment to prevent significant confusion.

PROBLEM #2. Maintenance Antidepressant Therapy.

The patient was initially started on Zoloft 25 mg and increased to 50 mg. Significantly, the patient experienced some increased restlessness and jitteriness which seemed to resolve after five to six days. The patient did not have any hypomania after completing ECT, did not have any significant confusion. His function was markedly improved overall.

PROBLEM #3. Psychotic Symptoms.

Initially, we had started Haldol 2 mg after the ECT was completed by decided to discontinue it due to severe akathisia. After discontinuing Haldol and observing the patient, he did not have any residual psychotic symptoms, but we must consider adding antipsychotic medication if the patient has return or preoccupation or somatic delusions.

PROBLEM #4. History of Clubbed Feet.

This has been significant for the patient. It seems to add to some component of his symptoms of somatic delusions. In addition, the family, especially the mother is extremely concerned and occasionally preoccupied with the patient's orthopedic condition.

MENTAL STATUS AT TIME OF DISCHARGE

Appearance and General Behavior

The patient is alert, oriented, well organized, well groomed, considerably improved compared to his admission mental status exam.

Mood and Affect

Mood is "good." There is no suicidal ideation, no hopelessness. The patient did not have psychotic symptoms.

Rate and Pattern of Speech and Thought

Speech and thought are all normal and appropriate and goal oriented.

Content of Speech and Thought

Perception

NAME: , WPIC #

Cognitive Functions

Cognitive function is intact witn good abstraction and judgment.

Insight

Insight and judgment to illness are intact.

NAME: , WPIC #

DSM-III-R MULTIAXIAL DIAGNOSTIC FORMULATION

	I. CLINICAL PSYCHIATRIC SYNDROMES AND V CODES S=Severity	Code	S
1.	MAJOR DEPRESSION WITH PSYCHOTIC SYMPTOMS, SEVERE, RECURRENT	296.34	
2.	RULE OUT BIPOLAR DISORDER	294.70	
3.	RULE OUT SCHIZOAFFECTIVE DISORDER	295 70	
4.	RULE OUT CHRONIC UNDIFFERENTIATED SCHIZOPHRENIA	295.92	

	II. DEVELOPMENTAL AND PERSONALITY DISORDERS	
1.	SCHIZOTYPAL PERSONALITY TRAITS	30122

	III. PHYSICAL DISORDERS AND CONDITIONS	
1.	STATUS POST ELECTROCONVULSIVE THERAPY	V67.59
2.	STATUS POST BILATERAL PEDAL EDEMA	782 3
3.	HISTORY OF CLUBBED FEET WITH SEVERAL SURGERIES	754 70

IV. OVERALL STRESSOR SEVERITY

NONE	MILD	MODERATE	SEVERE	EXTREME	CATASTROPHIC	UNSPECIFIED
1	2	[✓ 3]	4	5	6	7

V. FUNCTIONING LEVELS (AXIS V)

A. Past GAF Score: 45

B. Current GAF Score: 80

DISPOSITION

A. Rationale for discharge:
[✓ Treatment objective achieved] ___ Transfer to state hospital ___ AMA ___ Other

B. Referrals:

1. Comprehensive Care Clinic. The patient will have individual therapist, as well as psychiatrist.

C. Medications prescribed at discharge

Name of Medication	Schedule	Amount Prescribed at Discharge
1. Zoloft	50 mg p.o. q.day	

D. Other instructions given to the patient (e.g., physical activity, medication, and diet)

Maintain a stress level and good control. Follow through with outpatient therapy and contact the 10th floor if he has any questions or concerns.

E. Further treatment recommendations

___ None [✓ Individual therapy] ___ Group therapy ___ Family therapy

[✓ Pharmacotherapy] ___ Vocational training ___ Remedial education ___ Other

F. Were referrals and recommendations accepted by patient/family? ___ NO X YES (if no, explain)

		Print Name	Sign Name	Code	Date
Clinician or Resident	1.	Robert Levin, M.D.	Robert Levin MD	7450	01/11/94
Clinician or Resident	2.				
Faculty Physician	3.	Robert Levin MD	Robert Levin MD	7450	1/11/94

RL/njk
D: 01/11/94; T: 01/13/94
3274

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UNIVERSITY OF PITTSBURGH
WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
PSYCHIATRIC EVALUATION FORM

Date: 11/01/93 WPIC# ____________
Name: ________ , ____________
Evaluation Setting: DEC

PATIENT IDENTIFICATION   Is this patient a twin? _X_ NO ___ YES

The patient is 42-year-old, white, single male, who presents to the DEC voluntarily, accompanied by his father.

REASON FOR REFERRAL

The father endorses that the patient has been in the house for the last 12 years, with little motivation and did describe him as a "vegetable."

HISTORY OF PRESENT ILLNESS

According to the family, the patient is known to WPIC by one previous admission in 1980. The patient could not give any history regarding that particular admission but the father endorsed that the patient was significantly depressed at that time, having difficulty functioning at work, was quite depressed, was not eating and was hospitalized here at WPIC. He reports that the patient was given ECT and some unknown medication. Upon discharge, the patient was referred back home and outpatient follow-up. Since that time, he has been at home in his room in bed. The father endorses that he has done absolutely nothing and things have gotten worse over the last several months to the point that the patient has not been eating, despite being encouraged, and has lost 50 pounds in the last several months. He has not been sleeping and he is becoming more and more withdrawn. The father made an ultimatum several months ago indicating to the patient that he would have him committed if he did not get his act together and start doing some things instead of laying in his bed all day. The patient begged his father for a 30-day reprieve and yesterday that 30 days was up. It appears that the patient was encouraged to come in today because the father feels as though he needs help and is significantly depressed. The patient does report increased depression for the last 10 years, endorses hyposomnia, poor appetite, increased isolative behavior, anergia, anhedonia, hopelessness and suicidal ideation, without a specific plan. The patient does not endorse any precipitants with the exception that he is feeling "sick." He describes his arms and legs are getting heavier, that he cannot move them, that he has pain in his extremities and in his body. He reports that this is secondary to having held his nose and breath about five or six months ago. The patient denies any auditory or visual hallucinations. The patient denies paranoia. The patient denies drug or alcohol use and father concurs.

PAST PSYCHIATRIC HISTORY (IF ANY)

Hospitalized in 1980 at WPIC.

NAME: WPIC #

SUICIDAL IDEATION AND BEHAVIOR ___ NO _X_ YES (Explain below)

Past

Denies.

Current

The patient endorses ideation without a plan.

AGGRESSIVE IDEATION AND BEHAVIOR _X_ NO ___ YES (Explain below)

Past

Denies.

Current

Denies.

HISTORY OF DRUG AND ALCOHOL ABUSE _X_ NO ___ YES (Explain below)

Past

Denies.

Current

Denies.

FUNCTIONING LEVELS (AXIS V)

Past GAF Score: 60 Highest level of functioning in the past year for at least a few months	Current GAF Score: 40 Level of functioning at time of assessment

PERSONAL, DEVELOPMENTAL AND SOCIAL HISTORY

The patient's father reports that he was born with club feet and had used this a lot in his younger life as an excuse not to do things. He did graduate from high school without problems and received a college degree in political science. The father said that in 1980 he was working up until his depression and has not been working since that time. The father describes over the last 12 yeas, the patient has been a human "vegetable," laying in the house and in bed and he will not come out of the house.

SOCIAL STRESSORS (AXIS IV)
Description of Recent Stressors

None specified.

Rating of Overall Stressor Severity

NONE	MILD	MODERATE	SEVERE	EXTREME	CATASTROPHIC	UNSPECIFIED
1	2	3	4	5	6	[✓ 7]

SOCIAL SUPPORTS

His parents.

MEDICAL HISTORY AND PHYSICAL EXAMINATION
Active Medical Problems

Denied.

Current Medications (Include over the counter medications).

None.

Past Medical History

Negative.

Review of Systems

Negative.

Allergies X NO ___ YES (if YES, list below)

Nonallergic Adverse Drug Reactions X NO ___ YES

Physical Exam

Please see supplemental.

Vital Signs: (Sitting) BP 150/100 Pulse 102 Temp 36.8
(Lying) BP ___ Pulse ___ R.R. 20
(Standing) BP ___ Pulse ___

Current Health Provider

None.

NAME: ., WPIC #

SIGNIFICANT FAMILY MEDICAL AND PSYCHIATRIC HISTORY

The patient has a brother with schizophrenia. His mother and paternal grandmother have a history of depression.

IMPACT OF PATIENT'S ILLNESS ON FAMILY AND OTHER SUPPORT SYSTEMS

His father expresses concern about his isolative behavior and his increased depression.

MENTAL STATUS EXAMINATION

Appearance and General Behavior

The patient was a casually dressed, slightly disheveled male, who appears his stated age. The patient was cooperative throughout the evaluation.

Mood and Affect

The patient's mood was depressed, and his affect was depressed.

Rate and Pattern of Speech and Thought

Speech was clear, slightly disorganized and unpressured. Thought rate and pattern was organized and coherent.

Content of Speech and Thought

The patient focused on the somatic complaints he has been experiencing.

Perception

The patient denies auditory and visual hallucinations.

Cognitive Functions

The patient is alert and oriented times three.

Insight

The patient has no insight into the nature of his illness.

PATIENT STRENGTHS

1. Support of his family.
2. Articulate.
3. Physically healthy.

NAME: , WPIC #

SYMPTOM INVENTORY

01 Impaired Sensorium
02 Impaired Orientation and/or Memory
[✓ 03 Poor Concentration, Distractibility]
04 Self-Neglect
05 Bizarre Behavior
06 Self-Abusive Behavior
07 Delusions
08 Hallucinations
09 Thought Process Disorganization
10 Elation, Expansiveness
[✓ 11 Hyperactivity, Agitation]
12 Psychomotor Retardation
[✓ 13 Sleep Disturbance]
[✓ 14 Eating Disturbance]
[✓ 15 Sadness, Dysphoria]
[✓ 16 Suicidal Indicators]
17 Anxiety
18 Phobias
19 Obsession/Compulsions
20 Somatization, Hypochondriasis
21 Dissociative Symptoms
22 Sexual Problems
23 Alcohol Abuse
24 Abuse of Other Drugs
25 Homicidality, Assaultiveness
26 Antisocial Behavior
27 Impulsivity
[✓ 28 Social Withdrawal]
29 Unstable, Dramatic Behavior
30 Overdependent, Hypersensitiv Behavior
31 None of the Above

ASSESSMENT SUMMARY

This is a 42-year-old, white, single male, who presents to the DEC voluntarily, accompanied by his father. Both endorse a history of the patient being in the house for approximately 12 years, with the patient laying in bed or just staying in the home. It appears that over the last several months, his functioning has diminished. The patient has had a decreased appetite despite their encouraging him to eat, with a 50-pound weight loss over the last several months. He has been more hyposomnic and more isolative, and his father expresses concern about his continued decline. The patient does endorse increased depressive symptoms with somatic complaints of pain in extremities and body, feeling that his limbs are getting heavy and that he cannot move. He does blame this all on the fact that he held his breath and nose about five or six months ago. The patient denies any psychotic symptoms. He does endorse significant depression.

RECOMMENDATIONS FOR FURTHER EVALUATION

Additional History

Obtain through his father.

Diagnostic Assessments

As per treatment team.

TREATMENT RECOMMENDATIONS

Inpatient admission to the 10th floor.

NAME: , WPIC #

DSM-III-R MULTIAXIAL DIAGNOSTIC FORMULATION

I.	CLINICAL PSYCHIATRIC SYNDROMES AND V CODES S=Severity	Code S
1.	MAJOR DEPRESSION WITH PSYCHOTIC FEATURES	296.34
	Alternative diagnoses to be considered	
1.	RULE OUT ORGANIC MENTAL DISORDER NOT OTHERWISE SPECIFIED	294 80B
II.	DEVELOPMENTAL AND PERSONALITY DISORDERS	
1.	DEFERRED	799.90
III.	PHYSICAL DISORDERS AND CONDITIONS	
1.	NONE	

DISPOSITION

Name of Program or Facility	Admit/Appt Date
Admission to the 10th floor.	11/01/93

Were referrals and recommendations accepted by patient/family? X YES ___ NO (if NO explain)

Legal Status After Evaluation: Voluntary

EVALUATORS

		Print Name	Sign Name	Code	Date
Clinician or Resident	1.	Annette Baughman, R.N.	Annette Baughman RN	9469	11/01/93
Clinician or Resident	2.	Christina Smith, M.D.	Christina Smith, MD	7883	11/01/93
Faculty Physician	3.	Robert Marin, M.D.	Robert Marin	1246	11/01/93

AB/cme
D: 11/01/93; T: 11/01/93
8085/8086

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC 1-21-81

SOCIAL STUDY

Name: ______ , ______ Hospital No.: # ______ Social Worker: Robert DiFranco, MSW

IDENTIFYING INFORMATION

The patient is a 29 year old, white, single, male who was admitted on a voluntary commitment for suicidal ideation and depression for the past four weeks. The patient is the oldest of four children who is currenly living at home with his parents. Special consideration: the patient has a younger brother, , who was a patient in the Schizophrenic Module and is currently followed by the EPICS Program.

PRESENTING PROBLEM

In August, 1980, the patient began complaining of "feeling sick" to his parents. made repeated trips to the family doctor who could not find any physical complications. This continued for approximately one month and the patient was experiencing decreased sleep, appetite disturbance, increased agitation and a feeling of depression. In September, 1980, the patient moved back home with his parents due to a compounding problem of rent increase and other financial problems.

In September, 1980, his parents sent him to a private psychiatrist who started the patient on Sinequan. This medication did not improve the depression, in fact, became further depressed and began complaining of hallucinations. He was hospitalized at Western Pennsylvania Hospital but left AMA after four days and was then brought to WPIC by his parents.

FAMILY HISTORY & BACKGROUND INFORMATION

The patient is the oldest of four children having two younger brothers and younger sister. The youngest brother, , age 23 is currently living in Arizona and the youngest, , age 20 is a student at College.

The patient's mother is age 50 and is self-employed owning a small business in 's brother is also in the business. The patient's father is age 52 and is also self-employed as the owner of a dry cleaners and also a home remodeling business in , Pa. The patient has been employed by his father in the dry cleaning business throughout high school and college, this has been the patient's only job experience.

was born and raised in area of Pittsburgh. Mother relates that she had a normal pregnancy and delivery without complications. However, the patient had a congenital deformity which is club feet. As an infant, was bottle fed and mother reports no difficulty with feedings.

Mother states developmental milestones in her estimation were reached early. Although had club feet, he was without difficulty at nine months, using phrases at about 11 months, and toilet trained at about a year and a half. Regarding M 's club feet, mother states that as an infant, had to wear shoes with a bar in between when he went to bed. This was apparently very uncomfortable , thus had difficulty falling asleep as an infant.

At age 18 months, mother placed at D. T. Watson Home for Crippled Children where he remained for three months receiving physical therapy and having to wear casts. During this time, mother was only allowed to visit on weekends. She states that when she did visit was happy to see her, however, frequently cried. By age 3, had two operations for corrective surgery on his feet. At age 5½ started kindergarden without incidence and apparently a good adjustment to school. Throughout elementary school, he remained an A - B student and parents report no behavioral problems. 's major interest was reading, parents report he rarely participated in any athletic events. Mother characterizes as "pretty much a loner" that is, never initiating contact with peers but would interact when contact was initiated by others.

Problems began in the family after mother delivered her fourth child which was an unplanned and unwanted pregnancy. Mother experienced post-partum depression and received ECT treatment which she states had a positive effect.

experienced considerable difficulty adjusting to Junior High School which was a new setting for him. Mother states he began refusing to attend which lasted about 2-3 months, after this time, this behavior subsided. In high school, there were no particular behavior problems, as remained an A - B student and still a loner.

Throughout 's growing up years, he followed and looked up to his younger brother, , who was gregarious and athletic. He did not date in high school and had only a few friends. After high school, went straight into college at Pitt majoring in Political Science.

After graduation from college, he returned to the cleaning business with his father where he has remained working, very unhappy at times. However, states he cannot leave because he feels he is not qualified to do anything else. Father doesn't give much responsibility nor does push for much.

About two years ago, quit the cleaning business and went to work in his father's home remodeling business in , Pa. for only a month and then returned. Reason for leaving was boredom.

moved away from his family one year after college. He moved in with a roommate and stayed with him for 1½ years. Roommate moved out - went home - stayed home 1½ years and then got his own apartment. He'd been in this apartment about 2½ years when rent became too expensive and he moved back home. Before moving back home, mother states he had been complaining of feeling sick and went to different medical doctors. This was this past August. He then began to complain of being depressed.

did well academically in college, however,after graduating he returned to his father's business in which,admittedly by his parents, was responsible for only menial tasks. has remained in the cleaning business and parents report he shows no motivation or confidence to take on more responsibility. states himself, that he lacks confidence in himself and also that he is bored with his work at the family business. About two years ago, became extremely frustrated in which he states he had to quit. At this time, he began working in his father's home remodeling business but found this unsatisfying also and so returned to the dry cleaning business after two months.

One year after college, moved away from his family. He moved in with a roommate and maintained an apartment for 1½ years. After this, his roommate got married and returned home to his parents for another 1½ yerss. Again moved out but this time alone; he lived independently for 2½ years. One month prior to hospitalization, became depressed, gave up the apartment and returned home.

ASSESSMENT & PLANS

During 's hospitalization, he was treated with antidepressant medication which he did not respond well to. Also, he was given a trial of neuroleptics to rule out the possiblity of Schizophrenia since his brother has been diagnosed Schizophrenic and was delusional upon admission. The neuroleptics made very agitated and they were discontinued. was then recommended for ECT which he received; after his third treatment, he became very confused and disoriented for several days. The treatment was discontinued, however, had a positive effect. was discharged shortly afterwards, his follow-up outpatient therapy was to consist of Family Therapy and Individual Psychotherapy.

Robert DiFranco MSW

Robert DiFranco, MSW, ABTU

RD:pwc

DD: 1/21/81
DT: 1/21/81

UNIVERSITY OF PITTSBURGH

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

PSYCHIATRIC REHABILITATION AND ASSESSMENT SERVICES

NAME: **WPIC #:** **UNIT/CLINIC:** CCP

REF'D BY: Nina Bridenbaugh, LSW **DATE REF'D:** 2-27-96 **DATE RECV'D:** 3-1-96

TEST DATE(S): 4-16-96, 4-30-96, 5-6-96, 5-7-96, 5-13-96, 5-18-96, 5-19-96, 6-5-96

TESTS ADMINISTERED: Wechsler Adult Intelligence Scale - Revised (WAIS-R), Wechsler Memory Scale - Revised (WMS-R), Career Ability Placement Survey (CAPS), Career Orientation Placement and Evaluation Survey (COPES), Career Occupational Preference System Interest Inventory (COPS), Strong Campbell Interest Inventory (SCII), Wide Range Achievement Test - Revised (WRAT-R), Nelson-Denny Reading Test (Form F), Test Of Written Language - 2 (TOWL-2), Halstead-Reitan Neuropsychological Battery (HRNB), California Verbal Learning Test (CVLT), Connor's Continuous Performance Test (CCPT), Hooper Visual Organization Test, Rey Complex Figure, Short Category Test, Beck Depression Inventory (BDI), Minnesota Multiphasic Personality Inventory (MMPI), Multidimensional Self-Esteem Inventory (MSEI), SCL-90-R.

BACKGROUND AND REFERRAL INFORMATION:

The client, a 45 year old, white, single male, was referred to Psychiatric Rehabilitation and Assessment Services (PRAS) on 3/1/96 for vocational assessment and counseling, help with career selection and/or getting ready for a job by his therapist from the Comprehensive Care Program (CCP) of Western Psychiatric Institute and Clinic (WPIC), Nina Bridenbaugh, LSW. The client presents with a long history of depressive symptoms accompanied by complaints of debilitating, generalized somatic weakness and pain.

In August, 1980, at age 29 the client began to experience depressive symptoms, including decreased sleep, appetite disturbance with 50 pound weight loss, depressed mood, anhedonia, anergia, increased social isolation, increased agitation, decreased activities of daily living, somatic complaints, delusions, and intermittent suicidal ideation without a plan. In September, 1980, his parents sent him to a private psychiatrist, who started the client on Sinequan, but his depression worsened. The client was then hospitalized at Western Pennsylvania Hospital, but he left AMA after four days. The client was then admitted to WPIC from 10/9/80 - 12/18/80. During this time, he was treated for depression with ECT with marked improvment. The client did not comply with recommended outpatient treatment once returned to his parents home. Reportedly, from 1981 until his second admission to WPIC, at age 42 in 1993, the client had a severely retarded, withdrawn depression, and some psychotic symptoms, specifically, somatic delusions. He has been unable to work since 1980. His father brought him to the hospital in November 1993 and described him as a "human vegetable". During this second hospitalization, from 11/1/93 until 1/7/94, the client had a course of 16 ECT treatments, during which he experienced significant confusion which did resolve back to good cognitive functioning, again with marked improvement in depressive symptoms. Psychotic symptoms cleared with a brief trial of Haldol and did not return after Haldol was discontinued due to severe akathisia. The client was also treated with Zoloft 50 mg, which he continues to take. He was discharged to CCP for individual outpatient therapy and medication maintenance, with which he has been compliant. He attended group therapy for approximately seven months as well. The client received SSI in early 1995. The client has been diagnosed (12/28/94) as follows: Axis I: Major Depressive Disorder, Recurrent, Severe, With Psychotic Features (296.34), Axis II: Schizotypal Personality Disorder (301.22), Axis III: Status Post Electroconvulsive Therapy (V67.59) and Clubbed Feet (754.70), and Axis V: GAF of 60. However, at present the client presents with a GAF of 50.

Family history is positive for Bipolar Disorder in mother and younger sister and Schizophrenia in younger brother; Psychiatric symptomotology is denied in father and another younger brother.

The client has a congenital deformity, club feet, and has had multiple surgeries for this condition. He is unable to be on his feet for long and now has traumatic arthritis in his feet, as reported in his most recent physical exam (11/1/93). The client has a prescription for glasses, but he does not like wearing them, except for driving. At this time, the client appears overweight, which exacerbates the condition of his feet. The client walks with a noticeable limp.

Educationally, the client graduated from high school in 1969, attended the University of Pittsburgh, and received a Bachelor's degree in 1973 in Political Science. The client's work experience is limited to working with his father in a dry cleaning and home remodeling business. He did volunteer work at Shadyside Hospital in the Physical Therapy Department during the summer of 1995, and liked this. However, when the PT student interns returned in September 1995, there was no longer a role for him. He was offered another volunteer position in a clerical capacity which he declined. He has had no vocational activity since this time.

At this time, the client denies having ideas of reference, auditory or visual hallucinations, or feeling that his thoughts or actions are being controlled. The client reports that all he does during the day is listen to talk shows on the radio, eat, sleep and watch television. At this time, the client continues to take Zoloft 50 mg. The client expressed a vocational interest in the health care area, but he does not know what specific area he wants. The client's long term goal is to establish and follow through on a plan of action to aid in determining specified vocational goals.

TEST RESULTS AND DISCUSSION:

The client expressed genuine interest in engaging in vocational and educational assessment. The client appeared mildly anxious throughout testing sessions, but maintained excellent effort, and was most cooperative. The client had some difficulty sustaining concentration over lengthy (several hours) testing sessions and appeared to fatigue easily, hence testing was administrated over several different days. During different tests in the visual area, the client appeared to be squinting his eyes, but declined to put on his glasses. Throughout testing he was aware of personal weaknesses (visual spatial, constructional) and able to joke slightly about these, e.g. on Block Design. His approach to task was slow, cautious and deliberate.

Intellectual evaluation was conducted via the administration of the Wechsler Adult Intelligence Scale - Revised. This instrument provides a composite score (Full Scale IQ) which serves as an index of general intelligence as well as Verbal and Performance IQ scores. The results obtained were as follows:

Verbal IQ:	116
Performance IQ:	85
Full Scale IQ:	100

These scores are commensurate with functioning in the Average range of intelligence, with Verbal IQ in the High Average range and Performance IQ in the Low Average range. The 31 point spread between the Verbal and Performance IQ scores is statistically significant and indicates much better developed verbal comprehension abilities than perceptual organization abilities.

Further analysis of WAIS-R performance is available via subtest analysis. The Verbal Subtests consist of tasks which tap verbal conceptual ability, practical judgment and reasoning, numerical reasoning, immediate auditory attention, acquired knowledge, and general verbal proficiency. The Performance Subtests involve more visuoperceptual and visuomotor skills in task completion. Spatial and nonverbal reasoning skills are tapped in these tasks. In addition, demands are imposed for speed dependent performance on a number of these tests. Subtests are scored as Scaled Scores with a mean of 10 and a standard deviation of 3.

Verbal Subtests	Scaled Scores
Information	14
Digit Span	13
Vocabulary	14
Arithmetic	14
Comprehension	9
Similarities	9

Performance Subtests	Scaled Scores
Picture Completion	6
Picture Arrangement	7
Block Design	5
Object Assembly	6
Digit Symbol	7

Verbally, relative strengths are indicated by superior scores in three areas: 1) Information, or fund of and memory for general, factual everyday knowledge, reflecting social and educational background; 2) Vocabulary, or knowledge of word meanings, language development, verbal comprehension and expressive abilities; and 3) Arithmetic, a measure of speed of purely verbally-based mental numerical manipulation and reasoning abilities requiring attention, focused concentration and mental alertness. Another relative strength (high average) is in immediate auditory recall, freedom from distractability, and attention and concentration (Digit Span). Average scores were obtained on measures of social judgement, common sense, and utilization of practical information in everyday problem-solving situations (Comprehension), and in higher level abstract logical thinking and verbal concept formation (Similarities).

Non-verbally, the client's scores on measures of perceptual organization abilities ranged from borderline to the lower end of the low average range. Relative strengths (low average) are in visual-motor speed and coordination, capacity for rote learning of new material, and aptitude for clerical-like tasks (Digit Symbol), and in the ability to interpret social situations, logical planning ability and foresight (Picture Arrangement). Significant deficits lie in spatial visualization and non-verbal reasoning (perception, analysis and synthesis), the ability to see relationships among non-verbal material and perceptual organization ability (Object Assembly), and finally, in non-verbal conceptual ability, or the ability to see a picture as a whole and to differentiate essential from unessential detail.

Bannatyne recategorization of WAIS-R scores looks at three cognitive factors which have been linked with and are utilized in the processing of information and learning and a fourth factor labeled, Acquired Knowledge. The three primary factors consist of spatial, conceptual, and sequential ability areas, each of which is summarized by way of a mean rating. The spatial category is based upon the Block Design, Object Assembly, and Picture Completion subtests; the Conceptual category is based upon the Vocabulary, Similarities, and Comprehension subtests; and the sequential category is comprised of the Digit Span, Digit Symbol, and Arithmetic subtests. The final category, Acquired Knowledge is based upon the Information, Arithmetic, and Vocabulary subtests and thus generally reflects the impact of formal academic experiences. The client's Bannatyne recategorized scores result in the following profile:

Spatial	<	Conceptual	<	Sequential	<	Acquired Knowledge
M = 5.66		M = 10.66		M = 11.33		14

The above indicate borderline spatial abilities, average conceptual and sequential abilities, and superior knowledge acquired from formal educational experiences.

As a formal assessment of memory the Wechsler Memory Scale-Revised (WMS-R) was utilized. The WMS-R is an individuallyadministered, clinical instrument for appraising major dimensions of memory functions in adolescents and adults. The scale is intended as a diagnostic and screening device for use as part of a general neuropsychological examination, or any other clinical examination requiring the assessment of memory functions. The functions assessed include memory for verbal and figural stimuli, meaningful and abstract material, and delayed as well as immediate recall. There are eight subtests which comprise the scale, four of which serve as delayed-recall trials. The eight tests of short-term memory contribute to two major composite scores, General Memory and Attention/Concentration. The General Memory group is further subdivided into measures of Verbal and Visual Memory. The scaling of the WMS-R was constructed with a mean of 100 and a Standard Deviation of 15. The client's scores on this formal measure of memory are as follow:

	Standard Score	Range
Verbal Memory	105	Average
Visual Memory	89	Low Average
General Memory	97	Average
Attention/Concentration	108	Average
Delayed Recall	93	Average

The above results indicate fully average memory functioning except for low average visual-spatial memory. This relative deficiency in spatial ability is consistent across all tests administered.

A screening of academic skills was undertaken via administration of the Wide

Range Achievement Test-Revised (WRAT-R). Found below are the Standard Scores and Percentiles that were derived from the WRAT-R.

	Standard Score	**Range**
Reading Recognition	124	Superior
Spelling	125	Superior
Arithmetic	113	High Average

The client demonstrated superior knowledge of phonetics and spelling. Arithmetic ability is in the high average range and includes competence in basic math, fractions, percents and elementary Algebra.

Nelson-Denny Reading Test (Form F)

	Standard Score	Percentile Rank	Stanine	Standard Score
Reading Comprehension	105	62	6	Average
Reading Rate	104	61	6	Average

These scores, while at the upper end of the average range of ability, are somewhat lower than would be expected given the client's educational background and documented level of intellectual functioning, and reflect some degree of functional inefficiency in performance of a complex task such as reading, comprehending, and recalling a multi-paragraph story.

The Test Of Written Language - 2 (TOWL-2) was used in order to measure written expressive language involving both writing per se and the expression of ideas as a form of communication. The ability to write meaningfully is based upon at least three basic cognitive skills: (1) the ability to write in compliance with accepted standards, especially those governing punctuation, capitalization, and spelling; (2) the ability to use acceptable syntactic, morphologic and semantic elements of a given language; and (3) the ability to express ideas, opinions, and thoughts in a creative and mature way. These three abilities comprise the conventional, linguistic, and conceptual components of writing. The TOWL-2 is a measure which attempts to evaluate these three abilities. With the client, the spontaneous story subtest was utilized. Here one can get a measure of thematic maturity, contextual vocabulary, syntactic maturity, contextual spelling, and contextual style with results presented as percentile ranks and standard scores with a mean of 10. The client's scores on this subtest of the TOWL-2 follow:

	Percentile Rank	Standard Score	Range
Thematic Maturity	37	9	Average
Contextual Vocabulary	9	6	Low Average
Syntactic Maturity	16	7	Low Average
Contextual Spelling	9	6	Low Average
Contextual Style	16	7	Low Average

Again, these scores are somewhat lower than the client's superior verbal comprehension abilities and indicate some functional inefficiency in the ability to perform a multi-step, overall task, in this case, writing a short story.

A comprehensive neuropsychological evaluation was then undertaken utilizing the Halstead Reitan Neuropsychological Battery and ancillary procedures. Test data were analyzed using norms developed by Heaton, Grant and Matthews (1991) and permit demographic-corrected score conversion. This allows the individual's test performances to be compared with an appropriate normative peer group which is matched for gender, age, and level of education.

Assessment of basic language skills yielded essentially normal performance on measures targeting basic receptive and expressive language and there were no aphasic features. The client had no difficulty on tests of primary auditory processing of acoustic-rhythmic or phonemic stimuli. Performance on the Conner's Continuous Performance Test did not indicate attentional problem. Assessment of sensorimotor functions revealed within normal limits performance on measures targeting visual and auditory perception, however, there were a significant number of tactile errors on the Finger Tip Writing Test, with some performance asymmetry as well (more errors on the dominant right hand). Both hand performances were in the impaired range (T=32). Misperceptions on this test is a common finding in individuals with learning disability. Tactile form recognition was impaired only for the right hand. Moderate lateralizing effects were seen with the left hand performance on measures of psychomotor speed including the Grooved Pegboard (T=19 vs. T=22), and the Finger Oscillation Test (T=29 vs. T=37), and both hand performances were in the impaired range. Psychomotor speed was also impaired on the Smith Symbol Digit Test where performance was 1.0 Standard Deviation below the mean. On the Hand Dynomometer Test the right handed grip strength (43.5 kg.) was significantly greater than the left handed grip (29.0 kg.). Moderate motor imperceptions were noted on the Star Drawing Test as well. Of note, the client reported that he broke his left arm at age 13 and cracked his left wrist at age 16, which likely lowered his performance on the left side on the above measures of sensorimotor and motor measures.

On the Hooper Visual Organization Test visual-spatial perception was in the moderately impaired range, and the client also had significant difficulty with visual-motor organization on the Rey Complex Figure Test. Delayed recall was especially impaired (only 25%). Given this client's easy fatigue, the length of this assessment, and his already demonstrated impairments in visual-spatial and perceptual organization abilities, the Tactile Performance Test of the Halsted battery was not administered.

On the California Verbal Learning Test the client demonstrated average capacity for novel learning of discrete verbal material with repeated trials (Long-delay Free Recall = 81.2%). However, on the Category Test, a measure of abstraction, reasoning, and logical analysis--skills essential for organized planning and effective and efficient functioning in everyday life--the client's performance was in the mildly impaired range (T=34, 63 errors). This type of impairment is often misunderstood in persons with good educations, high IQs, and records of earlier achievements, but who are unable to successfully meet the requirements of everyday living.

Personality assessment was conducted via use of the Minnesota Multiphasic Personality Inventory, the SCL-90-R, the Multidimensional Self-Esteem Inventory (MSEI), and the Beck Depression Inventory (BDI).

The client's score on the BDI is in the normal range (not currently depressed). On the SCL-90-R, he had elevations on the Interpersonal Sensitivity Scale. The SCL-90-R is a 90-item self-report symptom inventory which yields a profile based upon nine primary symptom dimensions labeled Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. The client's profile indicates that he feels inadequate and inferior, has a poor self concept and lacks ego strength. People with this profile generally lack social skills and are extremely uneasy in dating situations.

On the MMPI, the client's profile is devoid of significant clinical scale elevations. Persons with this profile often present with adjustment disorders or psychiatric disorders, are usually defensive about psychological problems, and are apt to be naive, rigid and lacking insight. Approximately half of psychiatric inpatients with this "false normal" profile are psychotic and evidencing a Major Affective Disorder or Schizophrenia. Persons with similar profile types tend to make heavy use of the defense mechanisms of repression and denial, and are usually quite upset and distressed when they cannot present a facade of adequacy, formality, and moral virtue. The client also achieved a slight elevation (T=64) on the Schizoid Personality Disorder Scale of the MMPI. Individuals with this personality type tend to see themselves as bland and reflective. They are apt to be satisfied with their lives and content to remain aloof and socially detached. They are often difficultto energize, not emotionally conflicted, and untroubled by environmental circumstances. When they are pressed socially beyond their level of comfort they are likely to simply withdraw.

Results of the Multidimensional Self-Esteem Inventory indicate difficulties with global self-esteem, personal competency, expressing and receiving feelings of love, and maintaining an intimate relationship. Also, the client indicated difficulty in enjoying and getting along with others and that he appears to be lacking a sense of personal identity and purpose.

As an aid in vocational planning the California Career Occupational Preference System was utilized. The CCOPS is comprised of a vocational aptitude measure (CAPS), an interest inventory

(COPS), and a work values inventory (COPES). Specific vocational aptitudes are plotted against expressed interests and work-related values in the context of 14 major occupational cluster areas. These occupational cluster areas range from the Professional Science area to that of Service occupations and have been successfully correlated with the General Aptitude Test Battery and its resultant Occupational Aptitude Patterns. Scores are expressed as Stanines (1-9, with 9 being the highest score obtainable) and as Percentiles; those above the 75th Percentile and below the 25th Percentile are judged to be particularly relevant in the overall interpretation of test results.

On the CAPS, a measure of eight primary ability areas associated with the Occupational Clusters presented in the CCOPS vocational aptitude and interest battery, the following aptitude scores were derived:

	Primary Ability	Stanine Score	Percentile Score	Range
MR	Mechanical Reasoning	2	8	Borderline
SR	Spatial Relations	2	8	Borderline
VR	Verbal Reasoning	4	32	Average
NA	Numerical Ability	6	68	Average
LU	Language Usage	5	50	Average
WK	Word Knowledge	8	92	Superior
PSA	Perceptual Speed and Accuracy	6	68	Average
MSD	Manual Speed and Dexterity	4	32	Average

Enclosed with this report is a print-out of scores including Percentile Scores and those Occupational Clusters within which scores are high enough to consider them as potential areas for career exploration, dependent of course on expressed vocational interests and work values.

Also enclosed with the print-out are estimated scores on the General Aptitude Test Battery (GATB), as well as interpretive aids and statements useful in career counseling and exploration.

Scores on the CAPS help to evaluate relative strengths and weaknesses in terms of the eight abilities briefly described below.

MR Mechanical Reasoning measures understanding of basic mechanical facts and principles and the laws of physics. This ability is important in technical and mechanical fields, skilled trades and industrial arts, as well as many scientific and agricultural pursuits.

SR Spatial Relations measures the ability to visualize or think in three dimensions and mentally picture the position of objects in space from a two-dimensional diagram of picture. This ability is important in the arts, industrial arts, skilled trades, engineering and many scientific occupations.

VR Verbal Reasoning measures how well an individual can reason logically with words given facts and possible conclusions which may be drawn from those facts, and facility for understanding and using concepts expressed in words. The ability to reason accurately is important in general academic success, jobs requiring written or oral communication, science, service and business.

NA Numerical Ability measures basic computational skills, mathematical reasoning, and the ability to use numbers and work with quantitative materials and ideas. This ability is important in many school courses and is required in varying degrees in almost all of the scientific, technical, business and clerical fields.

LU Language Usage measures how well an individual can recognize and use standard English grammar, punctuation, and capitalization. This ability is important in jobs requiring written or oral communication, clerical jobs, professional level science occupations, and in all levels of business and service.

WK Word Knowledge measures how well a person can understand the meaning and precise use of words. This is important in communications and all professional level occupations involving high levels of responsibility and decision making.

PSA Perceptual Speed and Accuracy measures how well an individual can perceive small details rapidly and accurately with a mass of letters, numbers and symbols. This ability is important in office work and other jobs requiring fine visual discrimination.

MSD Manual Speed and Dexterity measures the ability to make rapid and accurate movements with the hands. This ability is important in Arts-Skilled and Technology-Skilled occupations and other jobs requiring speed and dexterity in the use of the hands.

Results on the CAPS are consistent with results of intellectual, psychoeducational, and neuropsychological evaluations in that verbal abilities are a relative strength and spatial and mechanical reasoning abilities are significantly impaired.

The Career Orientation Placement and Evaluation Survey (COPES) was administered in order to assess those personal values which have been repeatedly demonstrated to reflect major dimensions of job satisfaction. In conjunction with interests, what one would "like" to do, those domains which one values or perceives as important and worthwhile play an important role in career choice and job satisfaction. The work related values which are most important to the client are listed below; preference for the underlined work value is indicated by percentile rank.

Work Value Scale	Percentile Rank	Range
Investigative vs. Accepting	45	Average
Practical vs. Carefree	7	Borderline
Independence vs. Conformity	65	Average
Leadership vs. supportive	80	High Average
Orderliness vs. Non-Compulsive	51	Average
Recognition vs. Privacy	1	Deficient
Aesthetic vs. Realistic	1	Deficient
Social vs. Self-Concern	8	Borderline

The client's profile indicates that he strongly values work in which he may keep his activities private, and spend time on his own projects and affairs rather than as part of a team or helping others. He prefers to work on his own, free from rules, regulations and social conventions, and does not wish to have to rely on his sense of aesthetic appreciation in his work. These preferences are consistent with schizoid personality traits. Somewhat inconsistent with this profile is an indicated preference for a leadership vs. a supportive role in work, and counseling around the meaning of this apparent discrepancy is recommended.

The COPS-P is a self-report measure which allows the individual to select and more carefully define the kind of work which he/she may be interested in doing. Choices are given regarding a variety of activities which are performed and/or are a part of many and diverse occupations. The individual is asked to make choices based on personal interests rather than on consideration of factors such as salary, social standing, or future advancement. These many activities are then categorized with respect to the sixteen professional-level occupational clusters detailed in the CCOPSystem and reported as percentile ranks. The client's highest reported vocational interest areas fall under the career clusters of:

	Percentile
1. Service Social	89
2. Communication Written	76
3. Science Medical-Life	75

SERVICE, Social-Health occupations involve activities concerned with interpersonal relations in caring for the personal needs and welfare of others in fields of social service and health. Sample occupations include Nurse, Counselor, Speech Pathologist, Probation Officer, and Recreational Therapist.

COMMUNICATION, Written occupations involve activities concerned with skill in the use of written language especially in the creation or interpretation of literature and the written communication of knowledge and ideas. Sample occupations include Copy Writer, Editorial Assistant, Librarian, Technical Writer, Editor, and Reporter.

SCIENCE, Medical- Life occupations involve activities concerned with the conducting of research and the accumulation and application of systemized knowledge in medicine and the biological and life sciences. Sample occupations include Anesthesiologist, Pharmacologist, Physiatrist, Geneticist, and Biomedical Engineer.

Globally, the client's measured interest in social and health service occupations would appear to conflict with results of his personality assessment and measured work role and condition preferences. His measured interest in higher-level medical and life science careers may be contraindicated by his deficits in visual-spatial and perceptual organization abilities, skills essential to excel in the mathematics and science curriculum prerequisite to these careers.

A second measure of occupational interest was utilized to further explore the client's career interests. The Strong-Campbell Interest Inventory (SCII) yields systematic information about patterns in one's vocational interests and how these patterns compare with those of successful people in many occupations. Results are based on interests, not aptitudes or abilities. Indicated likes and dislikes are analyzed in three main ways: 1) "General Occupational Themes" for similarity to six important overall patterns; 2) "Basic Interest Scales", for similarity to 23 clusters of specific activities; and 3) "Occupational Scales", for similarity to the interests of men and woman successfully employed in 106 occupations.

Found below is the client's profile on the Six General Occupational Themes of the SCII. The range of scores is roughly from 30 to 70, with the average person scoring 50.

GENERAL OCCUPATIONAL THEME	SCORE	RANGE
Realistic	31	very low
Investigative	43	moderate low
Artistic	33	low
Social	50	average
Enterprising	43	moderate low
Conventional	35	very low

Of the 23 Basic Interest Scales of the SCII, the client's interest reached average or higher on the following scales:

BASIC INTEREST SCALE	SCORE	RANGE
adventure	49	average
science	49	average
medical science	52	average
teaching	49	average

social service	58	moderate high
medical	55	moderately high
domestic arts	46	average
law/ politics	54	average
merchandising	44	average
business management	46	average

The client's responses were at least moderately similar to those of persons working in occupations corresponding to the following 5 specific occupational scales of the SCII:

Bus Driver
Social Science Teacher
Speech Pathologist
Nurse, LPN
Funeral Director

There are two Special Scales on the SCII designed to yield additional insight into interests and expectations. The Academic Comfort Scale differentiates between people who enjoy being in an academic setting and those who do not. Persons with low scores (below 40) often are inclined to view education as a necessary hurdle for entry into a career, whereas persons with high scores (above 50) typically seek out academic courses. The client's score of 30 on this scale indicates a disclination toward formal academic coursework. The Introversion-Extroversion Scale is associated with a preference for working with things or ideas (scores above 55) or with people (scores below 45). The client's score of 61 on this scale indicates a strong preference for working with things or ideas.

Enclosed with this report is the client's comprehensive SCII Profile Report and further interpretive information.

SUMMARY AND RECOMMENDATIONS:

In summary, current overall intellectual functioning is within an Average, verbal comprehension abilities are within the High Average range, and perceptual organization abilities are in the Low Average range. Significant inefficiencies lie in visual-spatial perception and visual-motor organization. Mild impairment is noted in higher-level abstraction, reasoning, and logical analysis, skills essential for organized planning and effective and efficient functioning in everyday life. Personality assessment indicates schizoid tendencies and traits, interpersonal sensitivity, feelings of inadequacy and insecurity, and difficulty with social and intimate relationships, including "reading" the nonverbal behavior of others and social cues. Additionally, while the client appears to be somewhat socially inept, uncomfortable, and isolated with restricted affect, he does not appear to evidence the cognitive or perceptual distortions and eccentricities of behavior characteristic of persons with Schizotypal Personality Disorder. The above pattern of cognitive strengths and weaknesses, in conjuction with the client's characterological and behavioral manifestations, appear to warrant consideration of the diagnosis of a neurodevelopmental "nonverbal" learning disability.

Academic skills range from Superior phonetic and spelling skills, to High Average arithmetic skills, to Average reading rate and reading comprehension abilities, to Low Average writing skills. Memory functions, including attention and concentration, are within an Average range, except for Low Average memory for visual material. At present the client evidences considerable discrepancy among his expressed and inventoried career interests, his aptitudes, his work role and working condition preferences, and his measured cognitive and neuropsychological strengths and weaknesses.

Physically, the client evidences left-sided motor weakness and slowing, and mobility and related functional impairments secondary to clubbed feet and traumatic arthritis in his feet.

Psychosocially, the client has been unable to work since 1980 and has been supported by SSI since 1995. He resides in his elderly parents' home, and appears to have little social contact outside his family, except for mental health care services. Global Assessment of Functioning is currently estimated at no more than 50.

Recommendations include the following:

1. Orthopedic and physiatric evaluations to yield an assessment of the client's functional abilities and tolerances.
2. Continued career counseling and developmental learning experiences to further career development and involvement.
3. Continued monitoring of depressive and psychotic symptoms.
4. Continued individual psychotherapy.
5. Group experiences, of both a psychotheraputic and social-relational nature.

DSM-IV Diagnoses :

AXIS I : 296.33 Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features.

AXIS II : Schizoid Personality Traits.
315.9 Learning Disorder Not Otherwise Specified, Nonverbal type.

AXIS III : V 67.59 Status Post Electroconvulsive Therapy.
754.70 Clubbed Feet.

Michelle Geckle, M.Ed., CRC

Lynda J. Katz, Ph.D.
PLS#002855-L

Date: June 10, 1996

NAME: ___ ___ ______ **AGE:** 45 **BIRTH DATE:** 02|28|51

SS# ______ **DATE TESTED:** May, June 1996

INTELLECTUAL FUNCTIONING

Wechsler Adult Intelligence Scale, Revised

Verbal IQ	116	High Average
Performance IQ	85	Low "
Full Scale IQ	100	Average

Information	14	**Picture Completion**	6
Digit Span	13	**Picture Arrangement**	7
Vocabulary	14	**Block Design**	5
Arithmetic	14	**Object Assembly**	6
Comprehension	9	**Digit Symbol (Coding)**	7
Similarities	9		

Wide Range Achievement Test, Revised (WRAT-R)	**Standard Score**	**Percentile**	
Reading (Recognition)	124	95	Superior
Spelling	125	95	Superior
Arithmetic	112	81	High Average
	117	87	" "
Nelson-Denny			
Vocabulary			
Reading Comprehension	105	62	Average
Reading Rate	104	61	"
Woodcock			
Word Identification			
Word Attack			
Word Comprehension			
Passage Comprehension			
TOWL-2			
Thematic Maturity	95	Average	
Contextual Vocabulary	80	Low Average	
Syntactic Maturity	85	Low Average	
Contextual Spelling	80	Low Average	
Contextual Style	85	Low Average	

Boder

Reading Level		**Mental Age**	
Reading Age		**Reading Quotient**	
Nonspecific		**Dysphonetic**	
Dyseidetic		**Mixed**	

LANGUAGE

Aphasia Screening Test	0 x	
Boston Diagnostic Aphasia Exam		
Confrontation 105/105	0 x	
Responsive 30/30	0 x	
High Phrases 8/8	0 x	
Low Phrases 8/8		
Fluency		
Animals		
FAS	46	
Oral Comprehension		
Auditory		
Speech Sounds	5 x	
Rhythm	+ 29	Rank 1

MEMORY

Wechsler Memory Scale Revised (WMS-R)

Verbal Memory	105	Average
Visual Memory	89	Low Average
General Memory	97	Average
Attention/Concentration	108	Average
Delayed Recall	93	Average

REY Copy= 34/36 (70%)
Recall= 18/36 (25%)

SENSORY-MOTOR

IMPERCEPTIONS	**Raw Score**	**T-Score**
Tactile Errors R	0	
Tactile Errors L	0	
Auditory Errors R	0	
Auditory Errors L	0	
Visual Errors R	0	
Visual Errors L	0	
Tactile Finger Rec. R	0	
Tactile Finger Rec. L	0	
Finger Tip # Writing R	9 x	
Finger Tip # Writing L	5 x	
Tactile Form Rec. R	15"	
Tactile form Rec. L	12"	
Total Imperception R	9	
Total Imperception L	5	
Total R and L	14	
TACTILE/KINESTHETIC		
TPT Dominant Time		
TPT Non-Dominant Time		
TPT Both Time		
TPT Total Time		
TPT MEMORY		
TPT LOCLIZATION		
MOTOR		
Tapping Dom. (R)	44.4	
Tapping N-Dom. (L)	35.6	
Grooved Pegboard (R)	124"	
Grooved Pegboard (L)	152"	
Star Dom. (1x) R+ 6X	19"	
Star N-Dom. (1x) 9X	21"	
Grip Dom. R	43.5"	
Grip N. Dom. L	29"	

VISUO-SPATIAL

Hooper	+ 17.5	Mod. Impaired
Benton Judgment of Line		
Benton Visual Retention		
Benton Visual Form Recognition		

CONCEPTUAL/LEVEL OF PERFORMANCE

Categories	63 x	
Trails A (1x) 0. x	47"	
Trails B (x) 0. x	77"	
Raven SPM		
Stroop Color-Word		
Word		
Color		
Color-Word		
Interference		
Smiths	+ 45	- 1.0 S.D.
PASAT		
Series 1		
Series 2		
Series 3		
Series 4		

CVLT

List A Trial 1	8=50%	**List A Total**	55=68.7%
List A Trial 2	9=56.2%	**List B**	9=56.2%
List A Trial 3	11=68.7%	**Short Delay Free Recall**	13=81.2%
List A Trial 4	12=75%	**Short Delay Cued Recall**	12=75%
List A Trial 5	15=93.7%	Long-Delay free Recall	81.2
		Long-Delay cued Recall	75%

BANNATYNE RE-CATEGORIZED SCORES OF WAIS-R

Spatial		Conceptual		Sequential		Acquired Knowledge	
Block Design	5	Vocabulary	14	Digit Span	13	Information	14
Object Assembly	6	Similarities	9	Digit Symbol	7	Arithmetic	14
Picture Completion	6	Comprehension	9	Arithmetic	14	Vocabulary	14
Total x (mean)	5.66 <		10.66 <		11.33 <		14.0

WMS-R

PERCENTILES FOR SELECTED SCORES

	Raw Score	SS	Percentile	Rating SS
Digit Span Forward	12	133	99	Very Sup.
Digit Span Backward	10	124	95	Superior
Visual Memory Span Forward	5	70	02	Borderline
Visual Memory Span Backward	6	95	36	Average
Logical Memory I	27	106	66	Average
Logical Memory II	19	98	45	Average
Visual Reproduction I	25	97	19	Low Average
Visual Reproduction II	24	91	27	Average

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HRB NORMS PROGRAM
Raw Score Transformations

Name:
Age: 45
Date: 05/16/96
Handedness: Right

Sex: M
Years of Educ: 16
File Name:

Measure	Abbreviation	Raw Scores	Scaled Scores	T Scores
HALSTEAD REITAN BATTERY SCORES				
Halstead Impairment Index	HII			
Average Impairment Rating	AIR			
Category Test	CAT ERROR			
Trail Making Test-A (secs)	TRAIL A	47	6	32#
Trail Making Test-B (secs)	TRAIL B	77	9	44
Tact Perf Test-Time (min/blk)	TPT TIME			
Tact Perf Test-Memory (correct)	TPT MEM			
Tact Perf Test-Location (correct)	TPT LOC			
Seashore Rhythm (correct)	SSHOR RHYM	29	14	58
Speech Perception (errors)	SPCH PERC	5	10	46
Aphasia Screening (errors)	APHAS SCRN	0	13	63
Spatial Relations (rating)	SPAT REL			
Sensory-Perceptual Total (errors)	SP TOTAL	14	5	32#
LATERALIZED SENSORIMOTOR/ PSYCHOMOTOR INDICES				
Finger Tapping-Dom (taps)	TAP DH	44.4	8	37#
Finger Tapping-Non-dom (taps)	TAP NDH	35.6	6	29#L
Hand Dynamometer-Dom (kgs)	GRIP DH	43.5	10	38#
Hand Dynamometer-Non-dom (kgs)	GRIP NDH	29	8	32#L
Grooved Pegboard-Dom (secs)	PEG DH	124	3	19#
Grooved Pegboard-Non-dom (secs)	PEG NDH	152	3	22#L
Tact Perf Test-Dom (min/blk)	TPT DH			
Tact Perf Test-Non-dom (min/blk)	TPT NDH			
Tact Perf Test-Both Hands (min/blk)	TPT BOTH			
Sensory-Perceptual-Right (errors)	SP R	9	5	32#
Sensory-Perceptual-Left (errors)	SP L	5	6	35#
Tactile Form Recog-Right (secs)	TFR R	15	8	39#
Tactile Form Recog-Left (secs)	TFR L	12	9	43

# = Impaired
L = Right-left difference, with possible lateralizing significance

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HRB NORMS PROGRAM
Raw Score Transformations

Name:		Sex:	M
Age:	45	Years of Educ:	16
Date:	05/16/96	File Name:	
Handedness:	Right		

Measure	Abbreviation	Raw Scores	Scaled Scores	T Scores
ADDITIONAL TEST SCORES				
Thurstone Word Fluency (correct)	WORD FLUEN	46	9	42
Boston Naming (correct)	BSTN NAME			
BDAE Complex Material (correct)	BDAE COMP			
WCST Perseverative Responses	WCST PSVR			
Seashore Tonal Memory (correct)	SSHOR TONAL			
Digit Vigilance Time (sec)	DIGIT TIME			
Digit Vigilance Errors	DIGIT ERROR			
Story Learning (points/trials)	STORY LEARN			
Story Memory (% loss)	STORY LOSS			
Figure Learning (points/trial)	FIGUR LEARN			
Figure Memory (% loss)	FIGUR LOSS			
PIAT Reading Recog (percentile)	PIAT RECOG			
PIAT Reading Comp (percentile)	PIAT COMP			
PIAT Spelling (percentile)	PIAT SPELL			
WAIS-R SCORES				
Verbal IQ (VIQ)	VIQ	114	13	47
Performance IQ (PIQ)	PIQ	85	7	29#
Full Scale IQ (FSIQ)	FSIQ	100	10	35#
Information	INFO	14	14	53
Digit Span	DIGIT SPAN	11	12	47
Vocabulary	VOCAB	14	14	55
Arithmetic	ARITH	14	14	55
Comprehension	COMP	9	9	36#
Similarities	SIMIL	9	9	39#
Picture Completion	PICT COMP	6	6	32#
Picture Arrangement	PICT ARR	7	7	37#
Block Design	BLOCK DESGN	5	5	27#
Object Assembly	OBJ ASSMB	6	6	35#
Digit Symbol	DIGIT SYMB	7	7	39#

= Impaired

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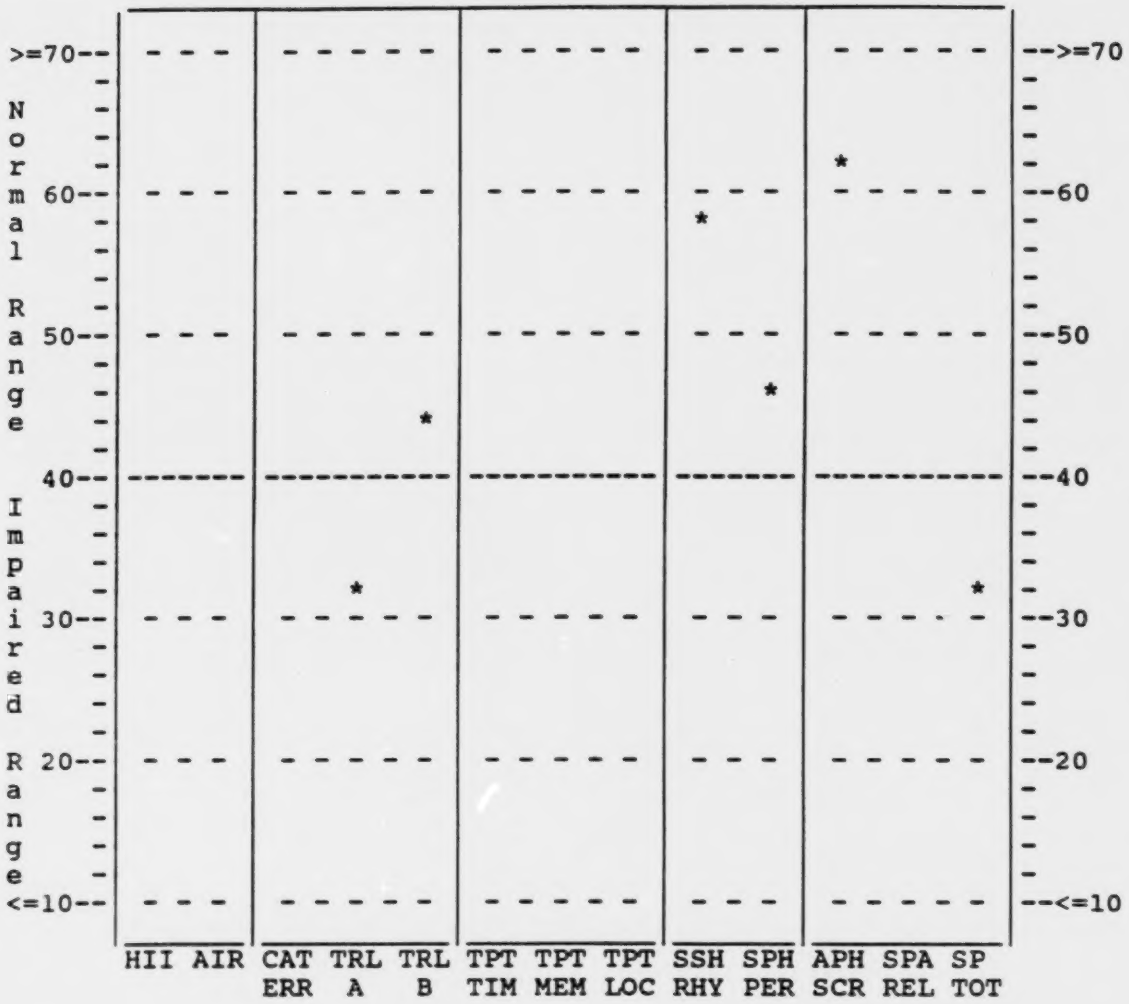
Name:
Age: 45
Date: 05/16/96
Handedness: Right

Sex: M
Years of Educ: 16
File Name:

Halstead-Reitan Battery T Score Profile

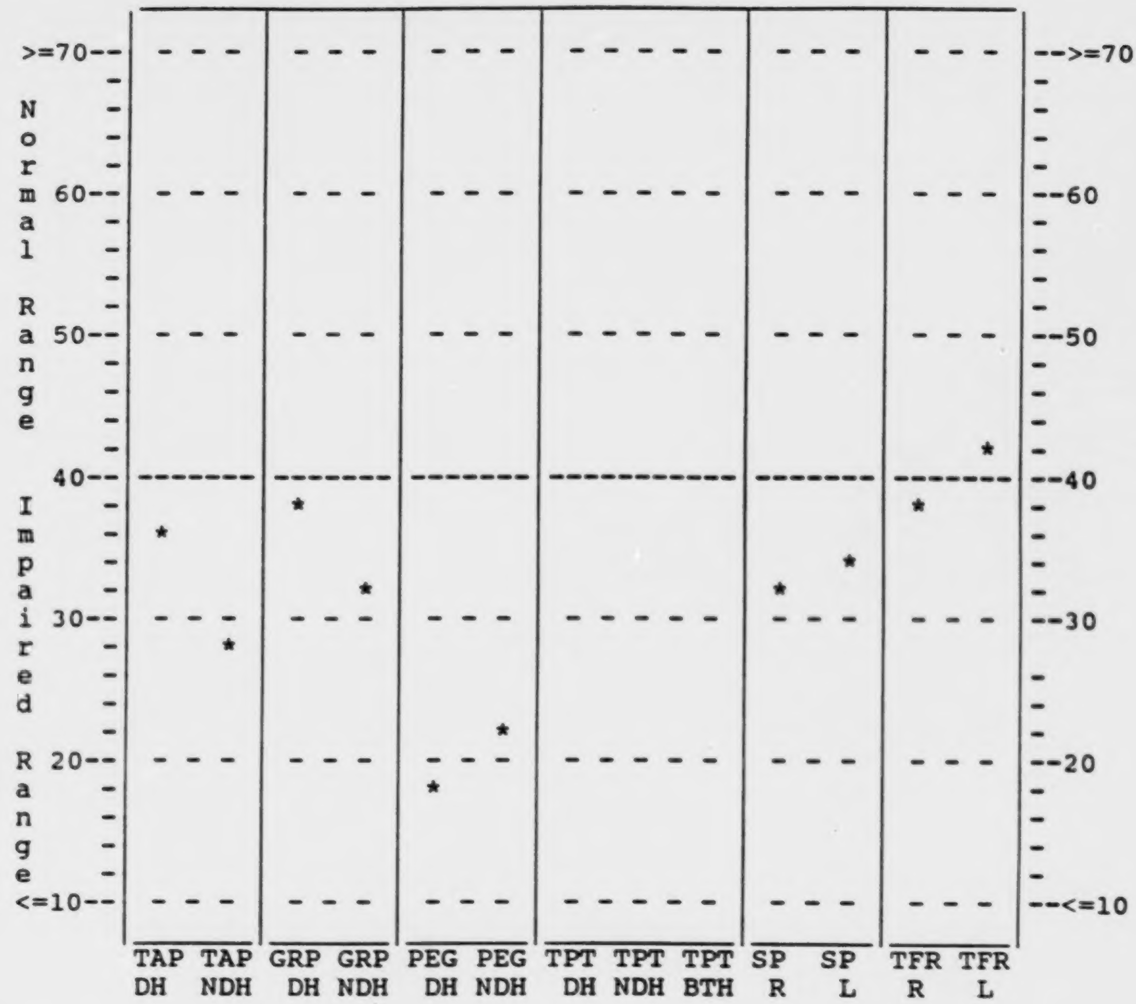


	HII	AIR	CAT ERR	TRL A	TRL B	TPT TIM	TPT MEM	TPT LOC	SSH RHY	SPH PER	APH SCR	SPA REL	SP TOT
T Score				32	44				58	46	63		32
Scaled				6	9				14	10	13		5

Name:
Age: 45
Date: 05/16/96
Handedness: Right

Sex: M
Yrs of Educ: 16
File Name:

Lateralized Sensorimotor/Psychomotor T Score Profile

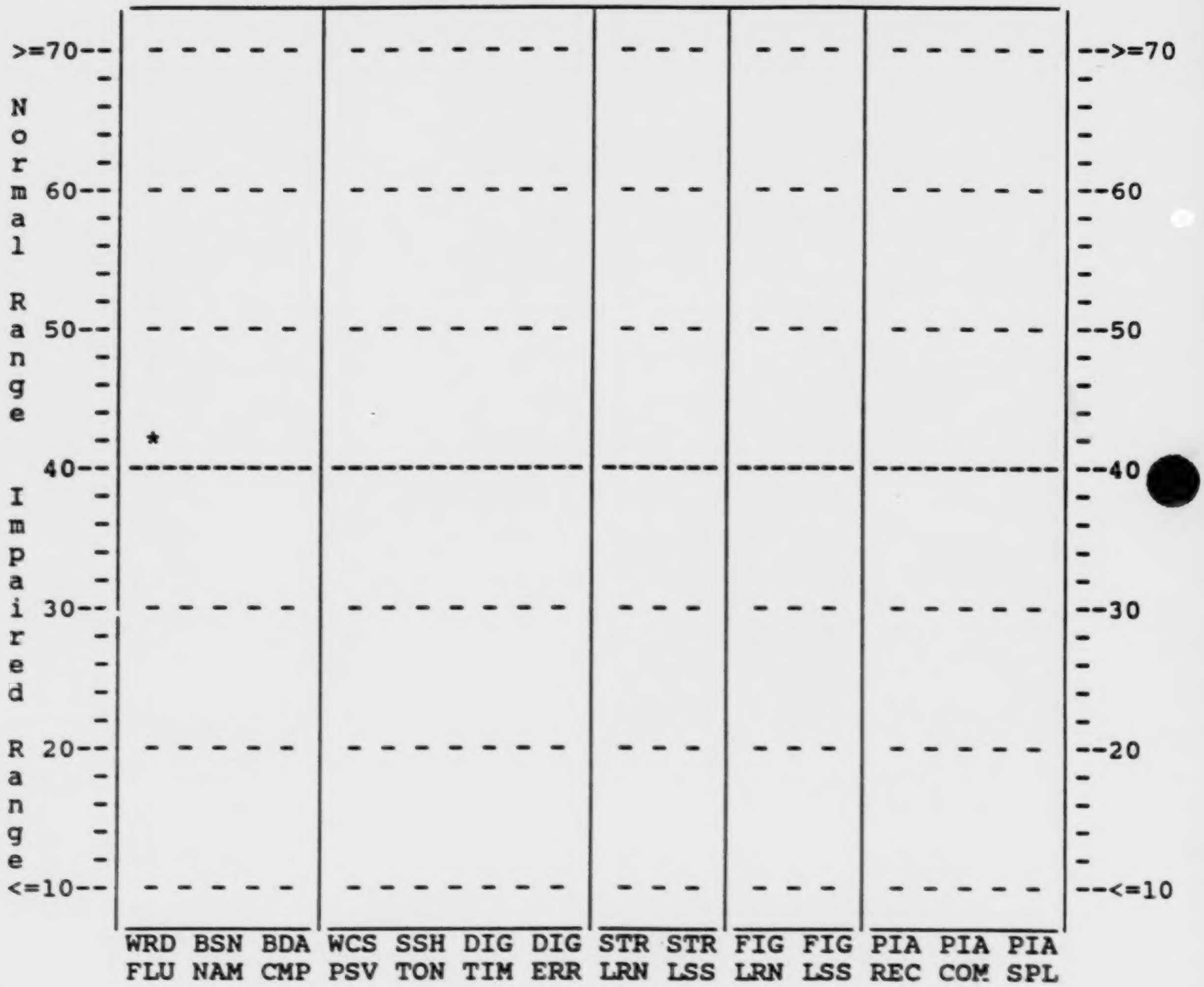


	TAP DH	TAP NDH	GRP DH	GRP NDH	PEG DH	PEG NDH	TPT DH	TPT NDH	TPT BTH	SP R	SP L	TFR R	TFR L
T Score	37	29	38	32	19	22				32	35	39	43
Scaled	8	6	10	8	3	3				5	6	8	9

Name:
Age: 45
Date: 05/16/96
Handedness: Right

Sex: M
Yrs of Educ: 16
File Name:

T Score Profile for Additional Tests

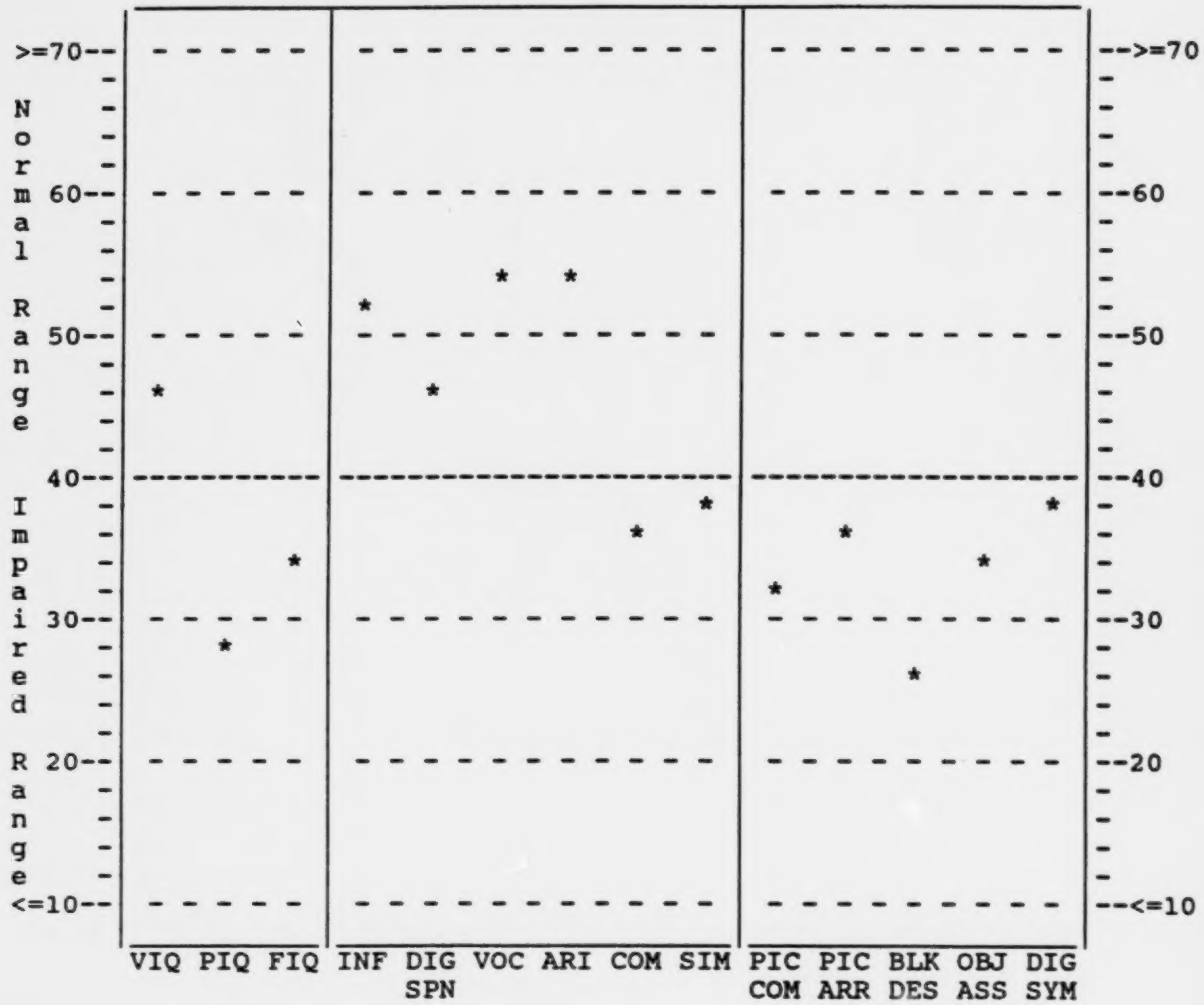


T Score 42
Scaled 9

Name:
Age: 45
Date: 05/16/96
Handedness: Right

Sex: M
Yrs of Educ: 16
File Name:

WAIS-R T Score Profile



	VIQ	PIQ	FIQ	INF	DIG SPN	VOC	ARI	COM	SIM	PIC COM	PIC ARR	BLK DES	OBJ ASS	DIG SYM
T Score	47	29	35	53	47	55	55	36	39	32	37	27	35	39
Scaled	13	7	10	14	12	14	14	9	9	6	7	5	6	7

CONNERS' CONTINUOUS PERFORMANCE TEST
Multi-Health Systems Inc.

Report For:
Patient/Subject #: 21
Birthdate (mmddyy): 02/28/51
Sex: M
Age: 45
Medication Type: Zoloft
Medication Amount: 50
Test #: 1
Tested (mmddyy): 05/07/96
Paradigm: STANDARD
Test Time: min: 14 sec: 10 ms: 630

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OVERALL SUMMARY BASED ON COMPARISON TO GENERAL POPULATION DATA

MEASURE	VALUE	T-SCORE	PERCENTILE	GUIDELINE
# Hits	317 (97.8%)	*	93.59	MARKEDLY ATYPICAL
# Omissions	7 (2.2%)	*	93.59	MARKEDLY ATYPICAL
# Commissions	7 (19.4%)	41.57	22.91	within average range
Hit RT	418.58	44.98	34.39	within average range
Hit RT Std Error	6.81	58.24	79.47	within average range
Variability of SEs	11.14	60.06	84.26	MILDLY ATYPICAL
Attentiveness (d')	2.93	53.66	67.93	within average range
Risk Taking (B)	0.18	86.54	99.00	MARKEDLY ATYPICAL
Hit RT Block Change	-0.02	38.78	15.36	within average range
Hit SE Block Change	0.03	53.59	67.69	within average range
Hit RT ISI Change	-0.08	18.95	1.00	within average range
Hit SE ISI Change	-0.18	34.04	5.53	within average range

* For hits and omissions, nature of data dictates use of percentiles only.

Conversions were made for HITS, HIT RT, and d' so that high T-scores (i.e., >= 60) provide evidence of a problem for ALL measures listed in the table. For example, without a conversion, a HITS T-score of 33 would indicate a lot of errors and a potential attention problem. This score of 33 is 17 BELOW the normative average of 50. To make high scores consistently indicative of a problem, this score is converted to 17 points ABOVE 50 which is 67.

Note that percentile values higher than 90 or 95 correspond to atypical responses. Percentile values must be much higher than T-scores before being considered atypical.

For B, both high AND low scores are noteworthy. Low scores indicate too frequent responding usually related to impulsivity. High T-scores for B indicate atypically low number of responses usually related to inattention.

The more measures showing up as atypical, the more likely that a problem exists. The presence of only one atypical measure does not usually indicate a problem.

INTERPRETIVE GUIDE

The Conners' CPT provides a rich source of information. The meaning of each individual component is presented first, then the information is synthesized into overall comments.

COMMENTS REGARDING THE TEST COMPONENTS:

Even in individuals with severe attention deficits, it is rare that all component measures will indicate attention problems. If 0 or only 1 component is atypical, this rarely is an indication of an attention problem. If 2 or more components are atypical, then the possibility of an attention problem should be considered more seriously. The more measures that are atypical, the more evidence there is for an attention problem.

Overall Processing Speed (Overall Hit Reaction Time)

This represents the average speed of correct responses for the entire test.

's response speed falls in the average range of the general population.

Overall Attentional Variability (Overall Standard Error)

High levels of variability indicate inconsistency in speed of responding - a sign of fluctuating attention from trial to trial.

's responses were about as consistent as other typical individuals from the population.

Speed Decrement Over Time (Pattern of Hit Reaction Time)

Some individuals tend to lack the ability to maintain their speed over time, indicating a loss of effort or energy in their responses.

's responses did NOT, however, slow down to any great degree over the course of the test.

Variability Over Time (Pattern of Standard Error)

f an individual becomes more variable over time in their speed of response, hen this may indicate a gradual loss of sustained attention.

's responses show no unusual loss of consistency over time.

Omissions

Inattentiveness may be caused by temporary blocks in responding, or actual looking away from the test when signals are presented. A high level of omissions indicates such a loss of attentiveness.

made an unusually high number of omission errors indicating inattentiveness.

Commissions

Commission errors may represent an inability to withhold motor responses as a result of an impulsive response tendency.

, however, did not make an unusually high number of commission errors.

erceptual Sensitivity (d')

Errors in responding may represent difficulties in discriminating the perceptual features of signals (all letters except X) and non-signals (Xs).

The value of d' for indicates about average perceptual sensitivity.

Response Bias (B)

Beta (B) represents an individual's response tendency: Some individuals are cautious and choose not to respond very often. These individuals will obtain high Beta T scores. Others are more risk-taking or impulsive and respond more frequently than they should. These individuals will obtain low Beta T scores.

's value of B indicates a response style which emphasizes the minimization of commission errors more than omission errors relative to the General Population.

Activation/Arousal (Inter-Stimulus Statistics)

People tend to adjust their speed of reactions according to how fast the stimuli occur. When the stimuli are presented quickly, brain activation/arousal is high and responses tend to be fast. When the stimuli are presented slowly, brain activation/arousal is low and responses tend to be slower and less consistent.

did not show any atypical change in response pattern when the letters were presented slowly.

OVERALL COMMENTS REGARDING 'S TEST

For most measures, 's performance on the Conners' CPT did not indicate attention problems. However, ...

...made a large number of omission errors indicating poor attention to the task.
...was highly inconsistent in responding indicating inattentiveness as measured by variability of SEs.

Overall INDEX = 4.44

Given that this particular combination of measures is not strongly associated with attention problems, and most measures were in the typical range, overall the Conners' CPT does NOT provide strong evidence of an attention problem.

Important Additional Notations

The comments in this report are based on general patterns apparent in the responses of . Always examine the graphs and information provided carefully to refine (and add to) the interpretations given. For instance, you will want to consider the statistics that are not explicitly discussed in this printed report. Please consult the Conners' CPT manual, or use the help keys while examining "on screen" reports for information about the measures.

VINCENT INTERPRETIVE REPORT
for the MMPI

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Ken R. Vincent, Ed.D
published by
Pacific Psychological
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Name/ID:
Age: 45   Sex: Male   Date: 06-05-96

This computer generated report should be considered a professional-to-professional consultation. All statements should be considered tentative and subject to further interpretation by a qualified mental health professional.

PROFILE VALIDITY

On the MMPI the person's validity scale configuration indicates that the profile is valid and depicts an individual who was open and honest in approaching the instrument.

PROFILE INTERPRETATION

The person's profile is devoid of significant clinical scale elevations. In outpatient settings, about half the time, such a performance is indicative of individuals who are presenting with either an adjustment disorder and/or marital problems, and who are quite often devoid of a personality disorder.

In psychiatric inpatients, the other extreme of the diagnostic spectrum is apt to be present in that approximately half of the persons producing this 'false normal' profile are psychotic and evidencing, most probably, a Major Affective Disorder (Major Depression or Bipolar Disorder) or to a lesser extent, Schizophrenia.

The remainder of individuals who produce this 'false normal' profile, in both inpatient and outpatient settings, tend to be in what pre-DSM-III terminology would be classified as chronic mixed neurotics. Such individuals are apt to present with somatoform disorders and psychological factors affecting physical conditions, as well as anxiety disorders or dysthymic disorders. The underlying personality of these persons are apt to be in a category of anxious and fearful personality disorder, namely, Avoidant, Dependent, Compulsive, Passive-Aggressive, though a small minority are seen as evidencing histrionic personalities.

Persons of this profile type are usually defensive about psychological problems and are apt to be naive, rigid, and lacking in insight. Such individuals tend to make heavy use of the defense mechanisms of repression and denial and are unduly conventional and insecure. Such individuals are quite apt to be resistant to psychotherapeutic intervention because of a fear of revealing themselves. They are usually quite upset and distressed when they cannot present a facade of adequacy, formality and moral virtue.

PERSONALITY (AXIS II)

Slight elevation of the SZD Personality Disorder Scale indicates a Schizoid Personality Type. These individuals see themselves as bland and reflective. They are satisfied with their lives and are content to remain aloof and socially detached. They are untroubled by intense emotions. They are difficult to energize and do not seem to be bothered by environmental circumstances.

They have little drive and generally are not emotionally conflicted. When they are pressed socially beyond their level of comfort they simply withdraw.

SPECIAL SCALE INTERPRETATION

The person has a significant low score on the Self-Alienation (Pd4B) Harris subscale. These individuals find daily life stimulating and rewarding. They are in general comfortable and happy. They do not express regret, remorse or guilt.

MMPI-83 Scoring Report
Version 2.0
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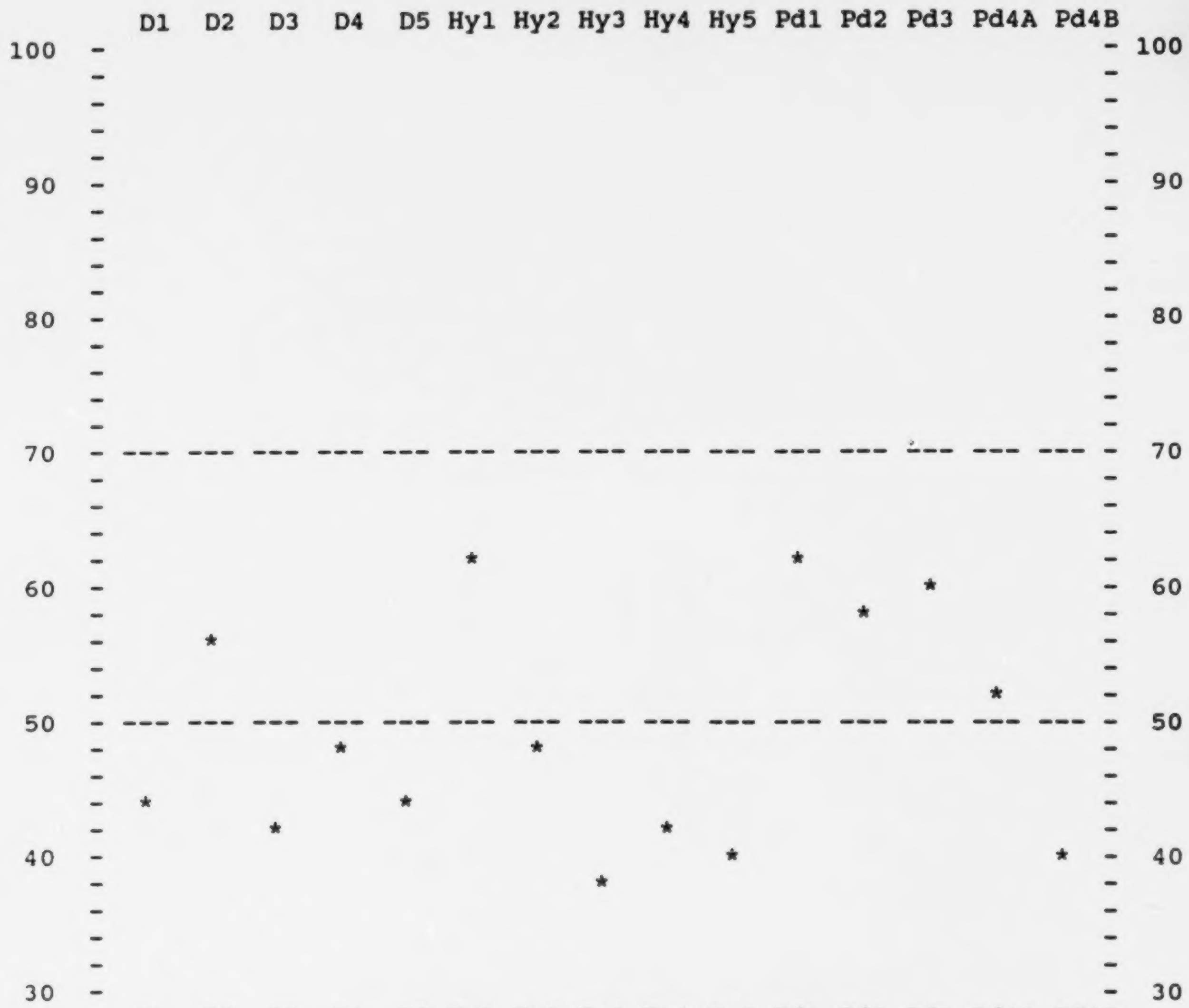
```
Name:
Age: 45          Sex: Male        Date: 06-05-96

        L    F    K    Hs    D   Hy   Pd   Mf   Pa   Pt   Sc   Ma   Si
100  -               I                                                  - 100
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
 90  -               I                                                  - 90
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
 80  -               I                                                  - 80
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
 70  - ---  ---  --- I ---  ---  ---  ---  ---  ---  ---  ---  ---  --- - 70
     -       *       I                                                  -
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
 60  -               I                                                  - 60
     -               I       *                   *         *            -
     -               I                 *    *                           -
     -               I                                                  -
     -               I                                                  -
 50  - ---  ---  --- I ---  ---  ---  ---  ---  ---  ---  ---  ---  -*- - 50
     -  *         *  I                                *                 -
     -               I            *                                     -
     -               I                                                  -
     -               I                                                  -
 40  -               I  *                                               - 40
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
     -               I                                                  -
 30  -               I                                          *       - 30
                        1    2    3    4    5    6    7    8    9    0
        L    F    K    Hs    D   Hy   Pd   Mf   Pa   Pt   Sc   Ma   Si
Raw     3   11   14     2   23   18   17   28   12   10   15    8   28
K-Corr                  9             23             24   29   11
Tscore 48   69   49    40   59   46   56   57   59   48   58   31   51
```

1764

This is a computer scoring report based primarily upon the 1983 census norms found in The MMPI, A Contemporary Normative Study by Colligan, Osborne, Swenson, and Offord. Permission was granted to use the "83" norms by Robert

```
                      FREQUENTLY SCORED SCALES

        A   R   Es MAS  Lb  Ca  Dy  Do  Re  Pr  St  Cn MAC O-H
100  -                                                         - 100
     -                                                         -
     -                                                         -
     -                                                         -
     -                                                         -
 90  -                                                         -  90
     -                                                         -
     -                                                         -
     -                                                         -
     -                                                         -
 80  -                                                         -  80
     -                                                         -
     -                                                         -
     -                                                         -
     -                                                         -
 70  - --- --- --- --- --- --- --- --- --- --- --- --- --- --- -  70
     -                                                         -
     -                                                         -
     -                                                         -
     -                                                         -
 60  -                              *                          -  60
     -                                              *       *  -
     -                                                         -
     -      *               *               *                  -
     -          *   *                           *              -
 50  - --- --- --- --- --- --- --- --- --- --- --- --- --- --- -  50
     -  *                               *                      -
     -                  *                                      -
     -                          *                              -
     -                                                         -
 40  -                                                         -  40
     -                                                         -
     -                                                         -
     -                                                         -
     -                                                         -
 30  -                                                  *      -  30
        A   R   Es MAS  Lb  Ca  Dy  Do  Re  Pr  St  Cn MAC O-H
Raw      9  19  48  14   9  13  15  20  20  12  21  28  14  16
T       49  54  52  52  47  55  45  60  48  54  53  58  30  59

A - Anxiety             R - Repression      Es - Ego Strength
MAS - Manifest Anxiety  Lb - Low Back Pain  Ca - Caudality
Dy - Dependency         Do - Dominance      Re - Social Responsibility
Pr - Prejudice          St - Social Status  Cn - Control
MAC - MacAndrews Alcoholism                 O-H - Overcontrolled Hostility
```

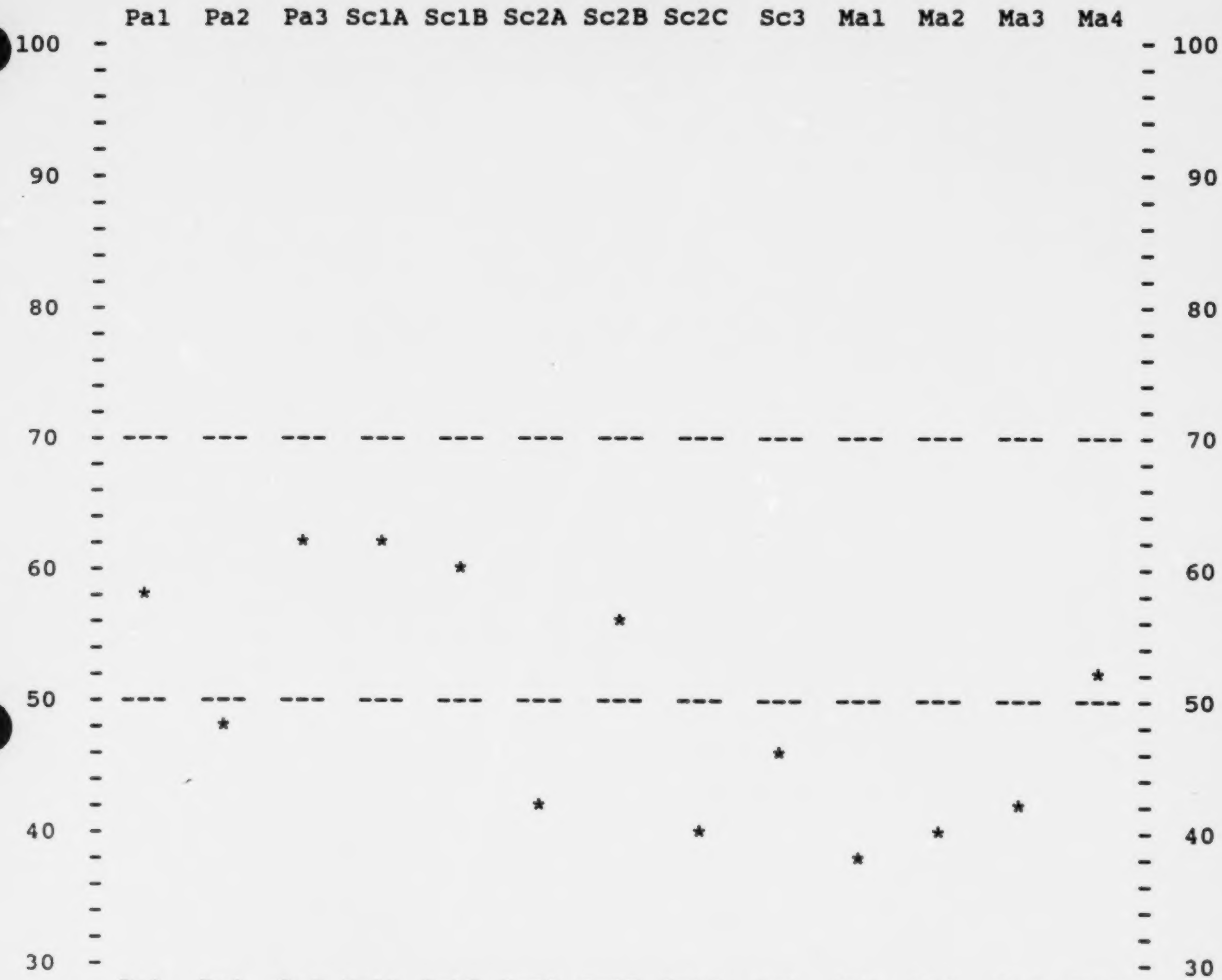
HARRIS SUBSCALES 1



	D1	D2	D3	D4	D5	Hy1	Hy2	Hy3	Hy4	Hy5	Pd1	Pd2	Pd3	Pd4A	Pd4B
Raw	5	7	2	2	1	6	6	0	1	2	4	6	10	6	1
T	45	56	43	48	45	63	49	39	42	40	63	58	61	53	40

D1 - Subjective Depression
D2 - Psychomotor Retardation
D3 - Physical Malfunctioning
D4 - Mental Dullness
D5 - Brooding
Hy1 - Denial of Social Anxiety
Hy2 - Need for Affection
Hy3 - Lassitude-Malaise
Hy4 - Somatic Complaints
Hy5 - Inhibition of Aggression
Pd1 - Familial Discord
Pd2 - Authority Problems
Pd3 - Social Imperturbability
Pd4A - Social Alienation
Pd4B - Self-Alienation

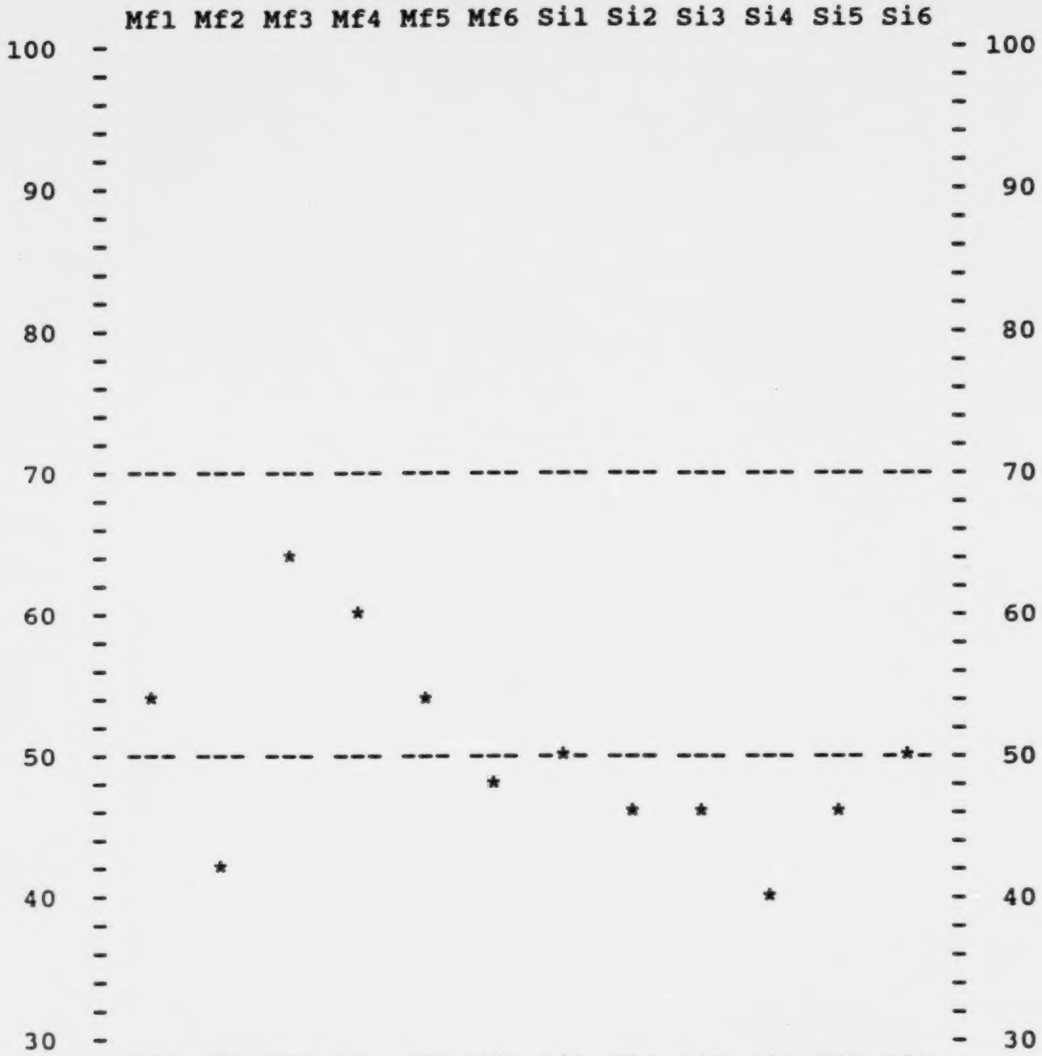
HARRIS SUBSCALES 2



	Pa1	Pa2	Pa3	Sc1A	Sc1B	Sc2A	Sc2B	Sc2C	Sc3	Ma1	Ma2	Ma3	Ma4
Raw	3	2	7	5	2	0	3	0	1	0	3	2	3
T	59	49	62	62	61	42	57	41	46	38	41	43	52

Pa1 - Persecutory Ideas
Pa2 - Poignancy
Pa3 - Naivete
Sc1A - Social Alienation
Sc1B - Emotional Alienation
Sc2A - Lack of Ego Mastery, Cognitive
Sc2B - Lack of Ego Mastery, Conative
Sc2C - Lack of Ego Mastery, Defective Inhibition
Sc3 - Bizarre Sensory Experiences
Ma1 - Amorality
Ma2 - Psychomotor Acceleration
Ma3 - Imperturbability
Ma4 - Ego Inflation

SERKOWNEK SUBSCALES



	Mf1	Mf2	Mf3	Mf4	Mf5	Mf6	Si1	Si2	Si3	Si4	Si5	Si6
Raw	7	2	6	3	4	5	10	3	8	1	4	2
T	54	43	65	61	54	48	51	46	46	41	46	50

Mf1 - Narcissism-Hypersensitivity

Mf2 - Stereotypic Feminine Interests

Mf3 - Denial of Stereotypic Masculine Interests

Mf4 - Heterosexual Discomfort-Passivity

Mf5 - Introspective-Critical

Mf6 - Socially Retiring

Si1 - Inferiority-Personal Discomfort

Si2 - Discomfort With Others

Si3 - Staid-Personal Rigidity

Si4 - Hypersensitivity

Si5 - Distrust

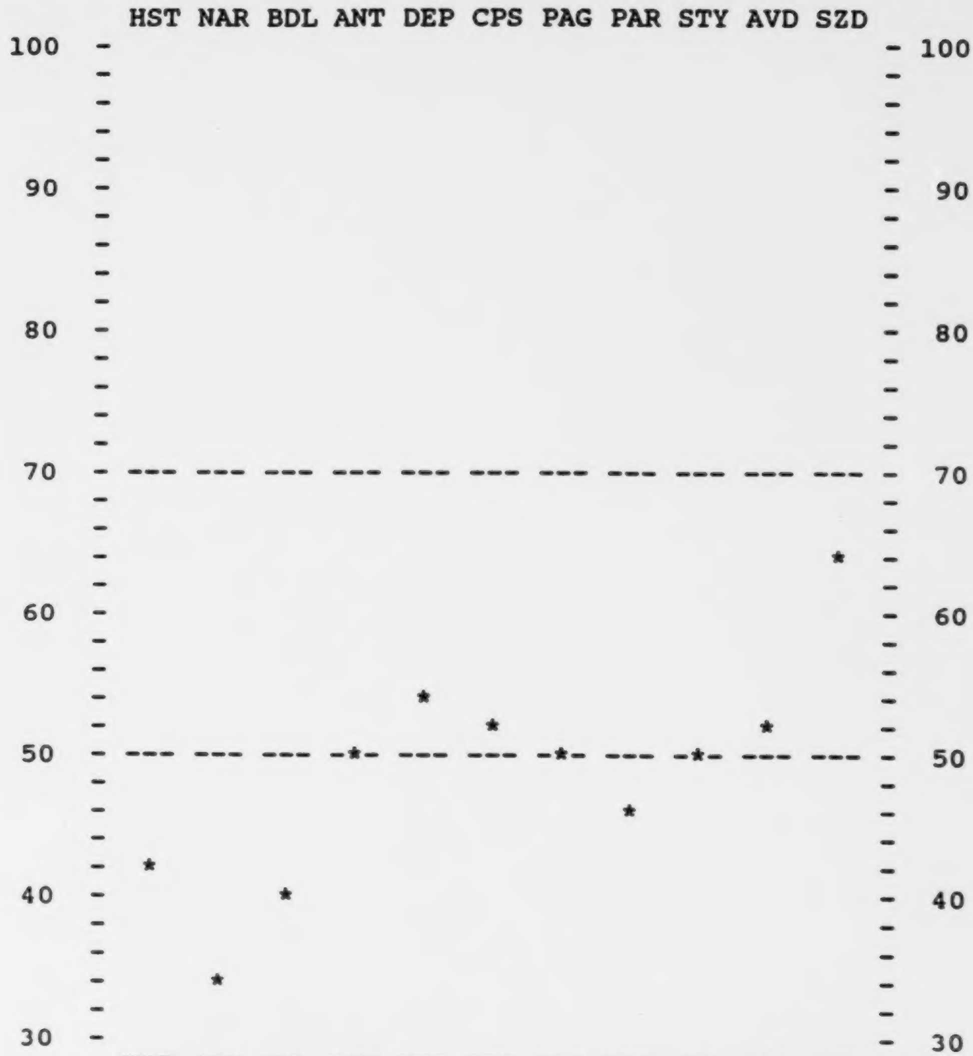
Si6 - Physical-Somatic Concerns

WIGGINS' CONTENT SCALES

```
       SOC DEP FEM MOR REL AUT PSY ORG FAM HOS PHO HYP HEA
100  -                                                     - 100
     -                                                     -
     -                                                     -
     -                                                     -
     -                                                     -
 90  -                                                     - 90
     -                                                     -
     -                                                     -
     -                                                     -
     -                                                     -
 80  -                                                     - 80
     -                                                     -
     -                                                     -
     -                                                     -
     -                                                     -
 70  - --- --- --- --- --- --- --- --- --- --- --- --- --- - 70
     -                                                     -
     -                                                     -
     -                                                     -
     -                                                     -
 60  -                                   *                 - 60
     -                                                     -
     -                                                     -
     -   *           *                                     -
     -                                                     -
 50  - --- -*- --- --- --- --- --- --- --- --- -*- --- --- - 50
     -           *                                         -
     -                                                     -
     -                       *       *                   * -
     -                                       *       *     -
 40  -                                                     - 40
     -                           *                         -
     -                                                     -
     -                                                     -
     -                                                     -
 30  -                   *                                 - 30
       SOC DEP FEM MOR REL AUT PSY ORG FAM HOS PHO HYP HEA
Raw     13   6   9   9   0   7   2   3   6   5   7   9   3
T       55  51  48  55  27  45  39  44  61  43  51  42  45


   SOC - Social Maladjustment      DEP - Depression
   FEM - Feminine Interests        MOR - Poor Morale
   REL - Religious Fundamentalism  AUT - Authority Conflict
   PSY - Psychoticism              ORG - Organic Symptoms
   FAM - Family Problems           HOS - Manifest Hostility
   PHO - Phobias                   HYP - Hypomania
   HEA - Poor Health
```

```
                          TSC CLUSTER SCALES

                    I    II  III   IV    V    VI  VII
             100 -                                   - 100
                 -                                   -
                 -                                   -
                 -                                   -
                 -                                   -
              90 -                                   -  90
                 -                                   -
                 -                                   -
                 -                                   -
                 -                                   -
              80 -                                   -  80
                 -                                   -
                 -                                   -
                 -                                   -
                 -                                   -
              70 - ---  ---  ---  ---  ---  ---  --- -  70
                 -                                   -
                 -                                   -
                 -                                   -
                 -                                   -
              60 -                                   -  60
                 -                                   -
                 -                                   -
                 -                 *                 -
                 -  *                                -
              50 - ---  ---  ---  ---  ---  ---  --- -  50
                 -                      *         *  -
                 -                                   -
                 -            *                      -
                 -                           *       -
              40 -                                   -  40
                 -       *                           -
                 -                                   -
                 -                                   -
                 -                                   -
              30 -                                   -  30
                    I    II  III   IV    V    VI  VII
             Raw     9    1    8    7    5    3    8
             T      52   39   45   54   48   42   49

I - Introversion  II - Body Symptoms  III - Suspicion  IV - Depression
V - Resentment    VI - Autism         VII - Tension
```

PERSONALITY DISORDER SCALES



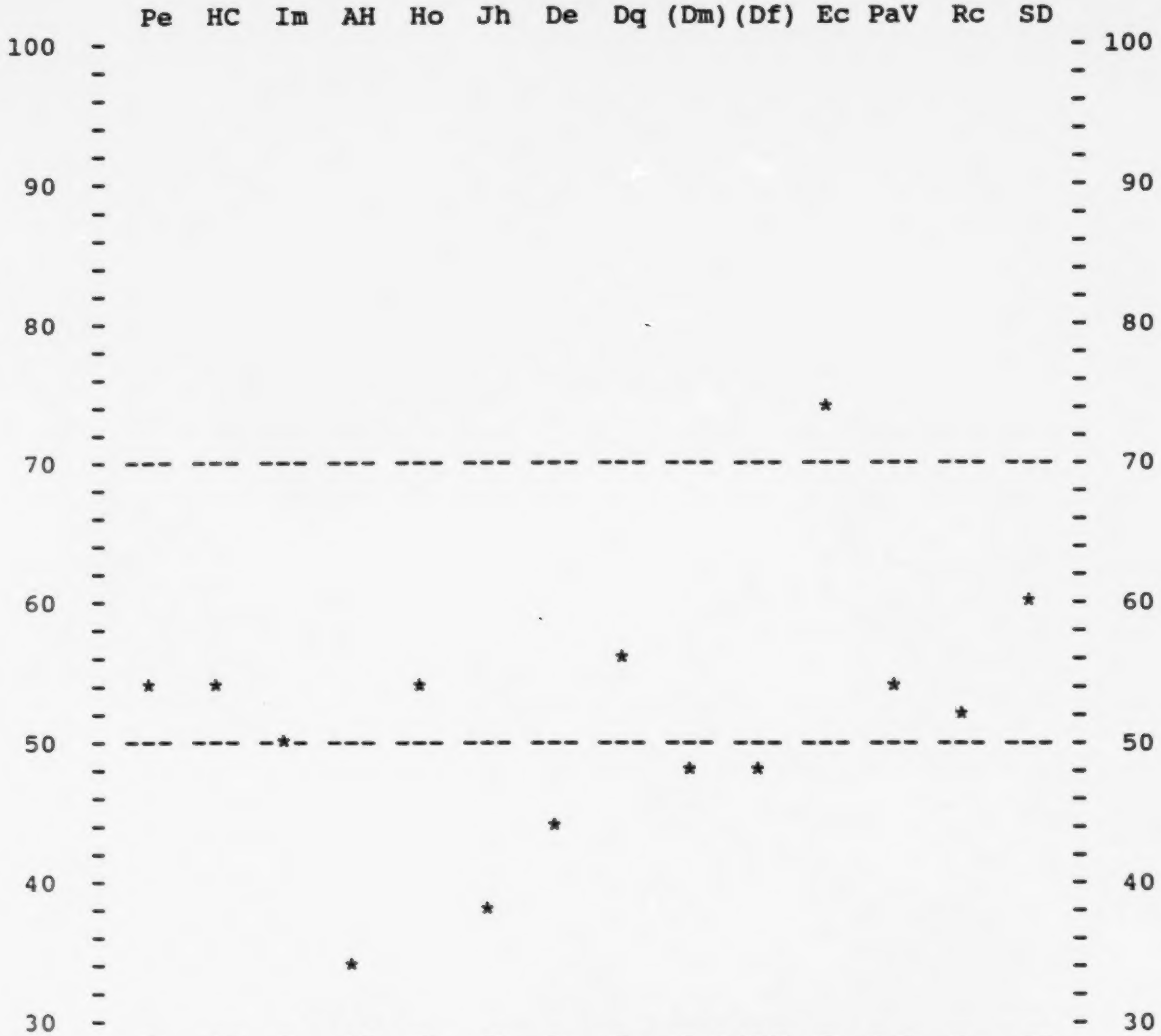
	HST	NAR	BDL	ANT	DEP	CPS	PAG	PAR	STY	AVD	SZD
Raw	9	10	4	7	7	8	5	4	9	14	12
T	43	35	41	50	55	52	50	46	50	52	64

HST - Histrionic
ANT - Antisocial
PAG - Passive-Aggressive
AVD - Avoidant
NAR - Narcissistic
DEP - Dependent
PAR - Paranoid
SZD - Schizoid
BDL - Borderline
CPS - Compulsive
STY - Schizotypal

```
            WEINER-HARMON SUBTLE-OBVIOUS SUBSCALES

       D-O  D-S Hy-O Hy-S Pd-O Pd-S Pa-O Pa-S Ma-O Ma-S
100  -                                                  - 100
     -                                                  -
     -                                                  -
     -                                                  -
     -                                                  -
 90  -                                                  -  90
     -                                                  -
     -                                                  -
     -                                                  -
     -                                                  -
 80  -                                                  -  80
     -                                                  -
     -                                                  -
     -                                                  -
     -                                                  -
 70  - ---  ---  ---  ---  ---  ---  ---  ---  ---  --- -  70
     -                                                  -
     -                                                  -
     -                                                  -
     -       *                   *                      -
 60  -                                                  -  60
     -                                     *            -
     -                 *                                -
     -                                *                 -
     -                                                  -
 50  - -*-  ---  ---  ---  ---  ---  ---  ---  ---  --- -  50
     -                      *                           -
     -            *                                     -
     -                                          *       -
     -                                                  -
 40  -                                                  -  40
     -                                                  -
     -                                                  -
     -                                                  -
     -                                                  -
 30  -                                               *  -  30
       D-O  D-S Hy-O Hy-S Pd-O Pd-S Pa-O Pa-S Ma-O Ma-S
Raw      8   14    3   16    5   12    4    8    4    4
T       51   63   46   57   48   62   55   59   44   30
```

```
D-O - Depression-Obvious             D-S - Depression-Subtle
Hy-O - Hysteria-Obvious              Hy-S - Hysteria-Subtle
Pd-O - Psychopathic Deviate-Obvious  Pd-S - Psychopathic Deviate-Subtle
Pa-O - Paranoia-Obvious              Pa-S - Paranoia-Subtle
Ma-O - Hypomania-Obvious             Ma-S - Hypomania-Subtle
```

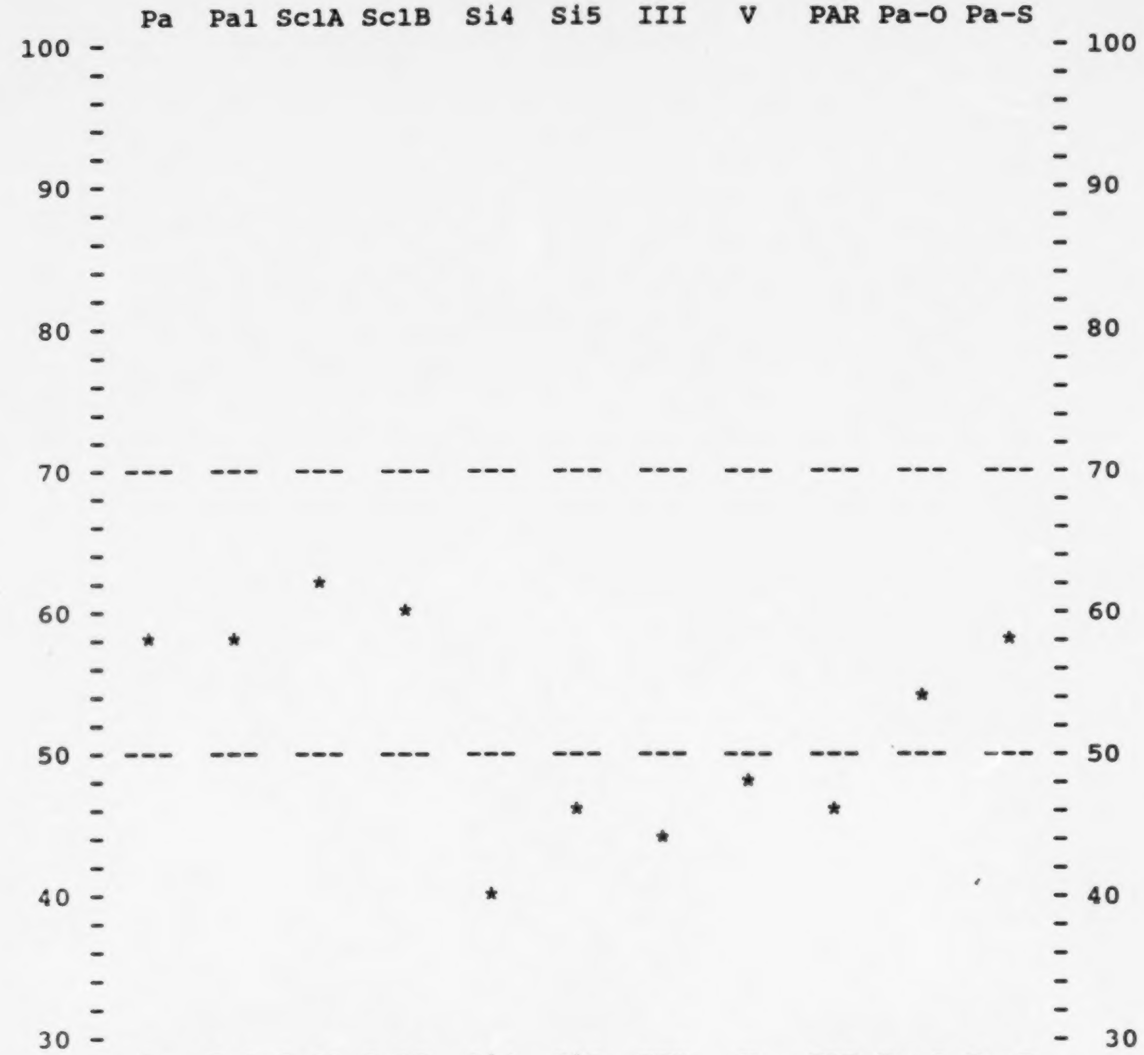
FORENSIC SCALES



	Pe	HC	Im	AH	Ho	Jh	De	Dq	(Dm)	(Df)	Ec	PaV	Rc	SD
Raw	5	27	7	0	9	8	2	10	20	32	19	11	8	13
T	54	54	51	35	55	39	44	56	48	49	74	54	53	61

Pe - Pedophile
Im - Impulsivity
Ho - Hostility
De - Delinquency
(Dm) - Delinquency Males
Ec - Escapism
Rc - Recidivism
HC - Habitual Criminalism
AH - Acting-out Hostility
Jh - Judged Manifest Hostility
Dq - Delinquency
(Df) - Delinquency Females
PaV - Parole Violation
SD - Socialized Delinquency

Paranoid-Sensitivity



	Pa	Pa1	Sc1A	Sc1B	Si4	Si5	III	V	PAR	Pa-O	Pa-S
Raw	12	3	5	2	1	4	8	5	4	4	8
Tscore	59	59	62	61	41	46	45	48	46	55	59

Pa - Paranoia
Pa1 - Persecutory Ideas
Sc1A - Social Alienation
Sc1B - Emotional Alienation
Si4 - Hypersensitivity
Si5 - Distrust

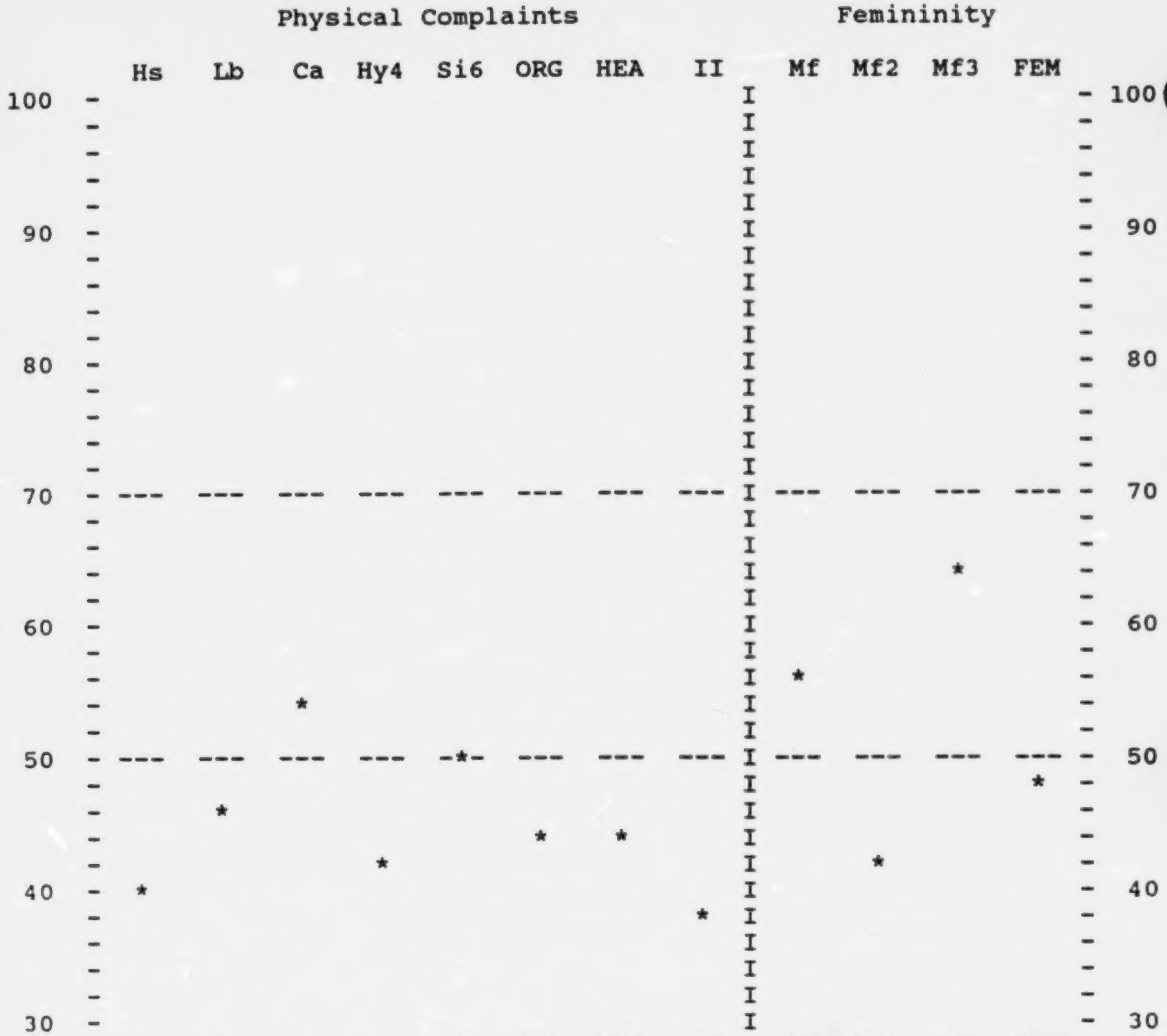
TSC-III - Suspicion
TSC-V - Resentment
PAR - Paranoid
Pa-O - Paranoia-Obvious
Pa-S - Paranoia-Subtle

Antisocial - Impulse Control

```
        Pd  Re Hy5 Pd2 Ma1 AUT BDL ANT Pd-O -S  HC  Im  Jh  De  Dq  SD
 100 -                                                                 - 100
     -                                                                 -
     -                                                                 -
     -                                                                 -
     -                                                                 -
  90 -                                                                 -  90
     -                                                                 -
     -                                                                 -
     -                                                                 -
     -                                                                 -
  80 -                                                                 -  80
     -                                                                 -
     -                                                                 -
     -                                                                 -
     -                                                                 -
  70 - --- --- --- --- --- --- --- --- --- --- --- --- --- --- --- --- -  70
     -                                                                 -
     -                                                                 -
     -                                                                 -
     -                                      *                          -
  60 -                                                              *  -  60
     -              *                                                  -
     -  *                                                       *      -
     -                                          *                      -
     -                                                                 -
  50 - --- --- --- --- --- --- --- -*- --- --- --- -*- --- --- --- --- -  50
     -      *                           *                              -
     -                                                                 -
     -                      *                               *          -
     -                                                                 -
  40 -          *               *                                      -  40
     -                  *                               *              -
     -                                                                 -
     -                                                                 -
     -                                                                 -
  30 -                                                                 -  30
        Pd  Re Hy5 Pd2 Ma1 AUT BDL ANT Pd-O -S  HC  Im  Jh  De  Dq  SD
Raw     17  20   2   6   0   7   4   7   5  12  27   7   8   2  10  13
Tscore  56  48  40  58  38  45  41  50  48  62  54  51  39  44  56  61
```

Pd - Psychopathic Deviate
Re - Social Responsibility
Hy5 - Inhibition of Aggression
Pd2 - Authority Problems
Ma1 - Amorality
AUT - Authority Conflict
BDL - Borderline
ANT - Antisocial

Pd-O - Psychopathic Deviate-Obvious
Pd-S - Psychopathic Deviate-Subtle
HC - Habitual Criminalism
Im - Impulsivity
Jh - Judged Manifest Hostility
De - Delinquency
Dq - Delinquency
SD - Socialized Delinquency



	Hs	Lb	Ca	Hy4	Si6	ORG	HEA	II	Mf	Mf2	Mf3	FEM
Raw	2	9	13	1	2	3	3	1	28	2	6	9
Tscore	40	47	55	42	50	44	45	39	57	43	65	48

Hs - Hypochondriasis
Lb - Low Back Pain
Ca - Caudality
Hy4 - Somatic Complaints
Si6 - Physical-Somatic Concerns
ORG - Organic Symptoms
HEA - Poor Health

TSC-II - Body Symptoms

Mf - Masculinity-Femininity
Mf2 - Stereotypic Feminine Interests
Mf3 - Denial of Stereotypic Masculine Interests
FEM - Feminine Interests

```
                 Depression                          Social Introversion

      D     D1    DEP   IV    D-O   D-S     Si    St    Hy1   Pd4A  Mf6   Si2   I
100 -                                     I                                           - 100
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
 90 -                                     I                                           - 90
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
 80 -                                     I                                           - 80
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
 70 - ---   ---   ---   ---   ---   ---   I ---   ---   ---   ---   ---   ---   ---   - 70
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
    -                                *    I              *                            -
 60 -                                     I                                           - 60
    -  *                                  I                                           -
    -                                     I                                           -
    -                    *                I                                           -
    -                                     I        *           *                 *    -
 50 - ---   ---   -*-   ---   -*-   ---   I -*-   ---   ---   ---   ---   ---   ---   - 50
    -                                     I                          *                -
    -                                     I                                *          -
    -        *                            I                                           -
    -                                     I                                           -
 40 -                                     I                                           - 40
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
    -                                     I                                           -
 30 -                                     I                                           - 30
      D     D1    DEP   IV    D-O   D-S     Si    St    Hy1   Pd4A  Mf6   Si2   I
Raw   23    5     6     7     8     14      28    21    6     6     5     3     9
Tscore59    45    51    54    51    63      51    53    63    53    48    46    52

    D - Depression                    Si - Social Introversion
    D1 - Subjective Depression        St - Social Status
    DEP - Depression                  Hy1 - Denial of Social Anxiety
    TSC-IV - Depression               Pd4A - Social Alienation
    D-O - Depression-Obvious          Mf6 - Socially Retiring
    D-S - Depression-Subtle           Si2 - Discomfort With Others
                                      TSC-I - Introversion
```

```
                Anxiety-Obsession              Mania-Energy Level

       Pt    A   MAS  D5   PHO  VII  CPS   Ma   D2   Ma2  HYP  Ma-O Ma-S
100 -                                    I                              -  10
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
 90 -                                    I                              -  90
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
 80 -                                    I                              -  80
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
 70 -  ---  ---  ---  ---  ---  ---  --- I ---  ---  ---  ---  ---  --- -  70
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
 60 -                                    I                              -  60
    -                                    I                              -
    -                                    I       *                      -
    -                                    I                              -
    -             *                   *  I                              -
 50 -  ---  ---  ---  ---  -*-  ---  --- I ---  ---  ---  ---  ---  --- -  50
    -   *    *                   *       I                              -
    -                                    I                              -
    -                  *                 I                      *       -
    -                                    I                 *            -
 40 -                                    I            *                 -  40
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
    -                                    I                              -
 30 -                                    I  *                        *  -  30
       Pt    A   MAS  D5   PHO  VII  CPS   Ma   D2   Ma2  HYP  Ma-O Ma-S
Raw    10    9   14    1    7    8    8     8    7    3    9    4    4
Tscore 48   49   52   45   51   49   52    31   56   41   42   44   30
```

Pt - Psychasthenia
A - Anxiety
MAS - Manifest Anxiety
D5 - Brooding
PHO - Phobias
TSC-VII - Tension
CPS - Compulsive

Ma - Hypomania
D2 - Psychomotor Retardation
Ma2 - Psychomotor Acceleration
HYP - Hypomania
Ma-O - Hypomania-Obvious
Ma-S - Hypomania-Subtle

```
            Psychoticism            Hostility & Anger   Family Problems
        Sc  Sc3  PSY   VI  STY    Do  O-H  HOS   AH   Ho   Pd1  FAM
 100 -                         I                         I          - 100
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
  90 -                         I                         I          -  90
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
  80 -                         I                         I          -  80
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
  70 - ---  ---  ---  ---  --- I ---  ---  ---  ---  --- I ---  --- -  70
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I          -
     -                         I                         I  *       -
  60 -                         I  *                      I       *  -  60
     -  *                      I       *                 I          -
     -                         I                         I          -
     -                         I                      *  I          -
     -                         I                         I          -
  50 - ---  ---  ---  ---  -*- I ---  ---  ---  ---  --- I ---  --- -  50
     -                         I                         I          -
     -       *                 I                         I          -
     -                         I                         I          -
     -                 *       I            *            I          -
  40 -                         I                         I          -  40
     -            *            I                         I          -
     -                         I                         I          -
     -                         I                 *       I          -
     -                         I                         I          -
  30 -                         I                         I          -  30
        Sc  Sc3  PSY   VI  STY    Do  O-H  HOS   AH   Ho   Pd1  FAM
Raw     15    1    2    3    9    20   16    5    0    9     4    6
Tscore  58   46   39   42   50    60   59   43   35   55    63   61

  Sc - Schizophrenism                O-H - Overcontrolled Hostility
  Sc3 - Bizarre Sensory Experiences  HOS - Manifest Hostility
  PSY - Psychoticism                 AH - Acting-out Hostility
  TSC-VI - Autism                    Ho - Hostility
  STY - Schizotypal                  Pd1 - Familial Discord
  Do - Dominance                     FAM - Family Problems
```

MSEI Profile Form / Males

Name

Age 45

Date 05-06-96

Percentile	T Score	GSE	CMP	LVE	LKE	SFC	PWR	MOR	BAP	BFN	IDN	DEF	T Score	Percentile	
99.9	80	50	50	50	47	49	50	50	50	50	50		80	99.9	
99.8	79									49			79	99.8	
99.7	78												78	99.7	Sig.
99.6	77			49					49				77	99.6	
99.5	76												76	99.5	
99.4	75												75	99.4	
99.2	74	49	49	48	46	48	49	49	48		49	63-64	74	99.2	
98.9	73	48				46-47			46-47			62	73	98.9	
98.6	72	47			45		48					61	72	98.6	
98.2	71			47		45		48	45		47-48		71	98.2	
97.7	70		48		44		47			48			70	97.7	
97.1	69				43		46	47	43-44	47		60	69	97.1	
96.4	68	46	47	46	42	44	45			46	45-46	58-59	68	96.4	
95.5	67	45					44				44	56	67	95.5	Mod-
94.5	66	44	46	45	41			46	42		43	55	66	94.5	High
93.3	65	43	45	44		43	43	45			42	54	65	93.3	
91.9	64		44						41	45	41	53	64	91.9	
90.3	63	42			40	42	42	44					63	90.3	
88.5	62		43	43						44			62	88.5	
86.4	61	41				41	41	43	40	43	40	52	61	86.4	
84.1	60			42	39	40			39			51	60	84.1	
81.6	59	40	42	41			40		38	42	39		59	81.6	
78.8	58			40		39	39	42			38	50	58	78.8	
75.8	57	39	41		38				37	41		49	57	75.8	
72.6	56			39		38	38	41		40		48	56	72.6	
69.1	55	38	40		37	■	37	40	36		37	47	55	69.1	
65.5	54	37	39	38					35	39		■	54	65.5	
61.8	53				36	36	36	39		38	36	45	53	61.8	
57.9	52	36	38	37			35		34				52	57.9	
54.0	51	35		36	35	35		38		37	35	44	51	54.0	
50.0	50		37		34	34	34		33		34	43	50	50.0	Average
46.0	49	34	36	35				37	■	36	33		49	46.0	
42.0	48	33		34	33	33	33	36		35		42	48	42.0	
38.2	47	32	35						31	34	32	41	47	38.2	
34.5	46			33	32	32	32	35		33	31	40	46	34.5	
30.9	45	31	34	32				34	30				45	30.9	
27.4	44			31	31	31	■		29	32	30	39	44	27.4	
24.2	43	30	33					■	28	31	29	38	43	24.2	
21.2	42	29		30	30	30	30		27			37	42	21.2	
18.4	41		32	29			29	32	26	30	28		41	18.4	
15.9	40	28	31	28	29	29			25	■	27	36	40	15.9	
13.6	39	■	■	27			28	31		28	26		39	13.6	
11.5	38	26		26	■	28	27	30	24	27	■	35	38	11.5	Med-
9.7	37	25	29		27				23	26	24	34	37	9.7	
8.1	36	24		25	26	27	26	29	22	25	23	33	36	8.1	Low
6.7	35	23	28	■	25			28	21	24	22		35	6.7	
5.5	34	22	27	23		26	25		20	23	21	32	34	5.5	
4.5	33			22			24	27	19	22		31	33	4.5	
3.6	32	21	26	21	24	25	23			21	20		32	3.6	
2.9	31	20	25		23			26		20	19	30	31	2.9	
2.3	30			19-20		24							30	2.3	
1.8	29	19			20-22	23	22	25	18	19			29	1.8	
1.4	28		24	18	19			22-24	17		18	29	28	1.4	
1.1	27	18			18	22	20-21	21	15-16			28	27	1.1	Sig.
0.8	26	17	23	16-17		21	19	19-20	14	17-18	15-17	27	26	0.8	
0.6	25												25	0.6	
0.5	24												24	0.5	Low
0.4	23	14-16	22	15	13-17		14-18	18	10-13	16	14		23	0.4	
0.3	22											17-26	22	0.3	
0.2	21												21	0.2	
0.1	20												20	0.1	

Scoring Grid

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15	12	13	13	20	13	22	21	10	10	15
GSE1	CMP1	LVE1	LKE1	SFC1	PWR1	MOR1	BAP1	BFN1	IDN1	DEF1
12	18	11	15	17	18	11	11	10	11	13
GSE2	CMP2	LVE2	LKE2	SFC2	PWR2	MOR2	BAP2	BFN2	IDN2	DEF2
								9	4	18
								BFN3	IDN3	DEF3
27	20	24	28	37	31	33	32	29	25	46
GSE	CMP	LVE	LKE	SFC	PWR	MOR	BAP	BFN	IDN	DEF

PAR

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9 8 7 6 5 4 3 2

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MSEI

Table 2
Characteristics of High and Low Scorers

Scale	High Scores	Low Scores
A. Global Self-esteem (GSE)	Pleased with self, feels significant as a person, self-confident, pleased with past, expects future successes.	Self-critical, dissatisfied with self, feels insignificant as a person, self-doubting, displeased with past, expects future failures unless major life changes are made.
B. Components of Self-esteem		
1. **Competence (CMP)**	Competent, feels capable of mastering new tasks, learns quickly and does well at most things, feels talented, feels effective and capable.	Incompetent, feels unable to master new tasks, learns slowly and often fails in difficult endeavors, ineffective, feels lacking in skills or talents
2. **Lovability (LVE)**	Worthy of love, feels cared for by loved ones, accepted as a person, can count on support from loved ones, able to express and receive feelings of love, involved in satisfying intimate relationship.	Unlovable, doubts that loved ones care, fears rejection because of certain aspects of personality, unsure whether loved ones can be counted on for support, has difficulty expressing or receiving feelings of love, doubts about finding or maintaining an intimate relationship.
3. **Likability (LKE)**	Likable, popular, accepted by peers and included in their plans, enjoyable companion, gets along well with others, popular in dating situations, expects to be liked, makes a good first impression.	Unlikable, unpopular, not accepted by peers and often excluded from peers' plans, has difficulty enjoying being with and getting along with others, unsuccessful in dating situations, fears rejection, and often makes a poor first impression.
4. **Personal Power (PWR)**	Powerful, successfully seeks positions of leadership, good at influencing others' opinions and behaviors, assertive, has a strong impact on others.	Powerless, poor leader and avoids leadership positions, a follower who is strongly influenced by others' opinions and behaviors, unassertive, rarely has a strong impact on others.
5. **Self-control (SFC)**	Self-disciplined, persevering, good at setting and achieving goals, not easily distracted, in control of emotions, exercises restraint in eating, drinking, and/or use of drugs.	Lacks self-discipline, often fails to complete tasks, difficulty with setting and achieving goals, easily distracted, not in control of emotions, lacks self-control in eating, drinking, or use of drugs.
6. **Moral Self-approval (MOR)**	Pleased with moral values and behavior, has clearly defined moral standards and acts in a way that is consistent with moral values, sets a positive moral example for others.	Guilty and displeased with moral values or behavior, unclear about moral beliefs and standards, often acts in an unethical or immoral manner, ashamed of setting a poor moral example for others.
7. **Body Appearance (BAP)**	Physically attractive, pleased with appearance, feels that others are attracted because of appearance, feels sexually attractive, takes care to enhance physical appearance.	Physically unattractive, displeased with appearance, feels that others are repelled by their looks, doubts sexual attractiveness, indifferent or unaware of ways to improve physical appearance.
8. **Body Functioning (BFN)**	Well-coordinated, agile, in good physical condition, comfortable with body, enjoys physical activities such as dancing or sports, feels healthy and feels a sense of vitality and vigor in body functioning.	Awkward, clumsy, uncoordinated, in poor physical condition, uncomfortable with body, dislikes engaging in physical activities, feels unhealthy and that body is dull, lifeless, and sluggish.
C. Identity Integration (IDN)	Clear sense of identity, knows who he/she is, knows what he/she wants out of life, well defined long-term goals, inner sense of cohesion and integration of different aspects of self-concept.	Confused, lacking a sense of identity and purpose, unsure of what he/she wants out of life, no long-term goals, much inner conflict among different aspects of self-concept.
D. Defensive Self-enhancement (DEF)	Defensive, overly inflated view of self-worth, claims to possess highly unlikely positive qualities, denies ubiquitous human weaknesses.	Open, nondefensive evaluation of self-worth, makes no claims of rare virtues, and acknowledges common human weaknesses.

70 & ↑ Significantly High
60-69 Moderately High
40-59 Average
30-39 Moderately Low
29 & ↓ Significantly Low

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COPS- P *04\30\96*

His three highest interest areas are:

1. *Service Social*
2. *Communication Written*
3. *Science Medical- Life*

Strong- Interest Inventory *04\30\96*

General Occupational Theme	*Score*	*Range*
(R) Realistic	*31*	*very low*
(I) Investigative	*43*	*mod. low*
(A) Artistic	*33*	*low*
(S) Social	*50*	*average*
(E) Enterprising	*43*	*mod. low*
(C) Conventional	*35*	*very low*

Basic Interest Scale	*Score*	*Range*
(R) Adventure	*49*	*average*
(I) Science	*49*	*average*
(I) Medical Science	*52*	*average*
(S) Teaching	*49*	*average*
(S) Social Service	*58*	*mod. high*
(S) Athletics	*58*	*average*
(S) Domestic Arts	*46*	*average*
(E) Law- Politics	*54*	*average*
(E) Merchandising	*44*	*average*
(E) Business Management	*46*	*average*

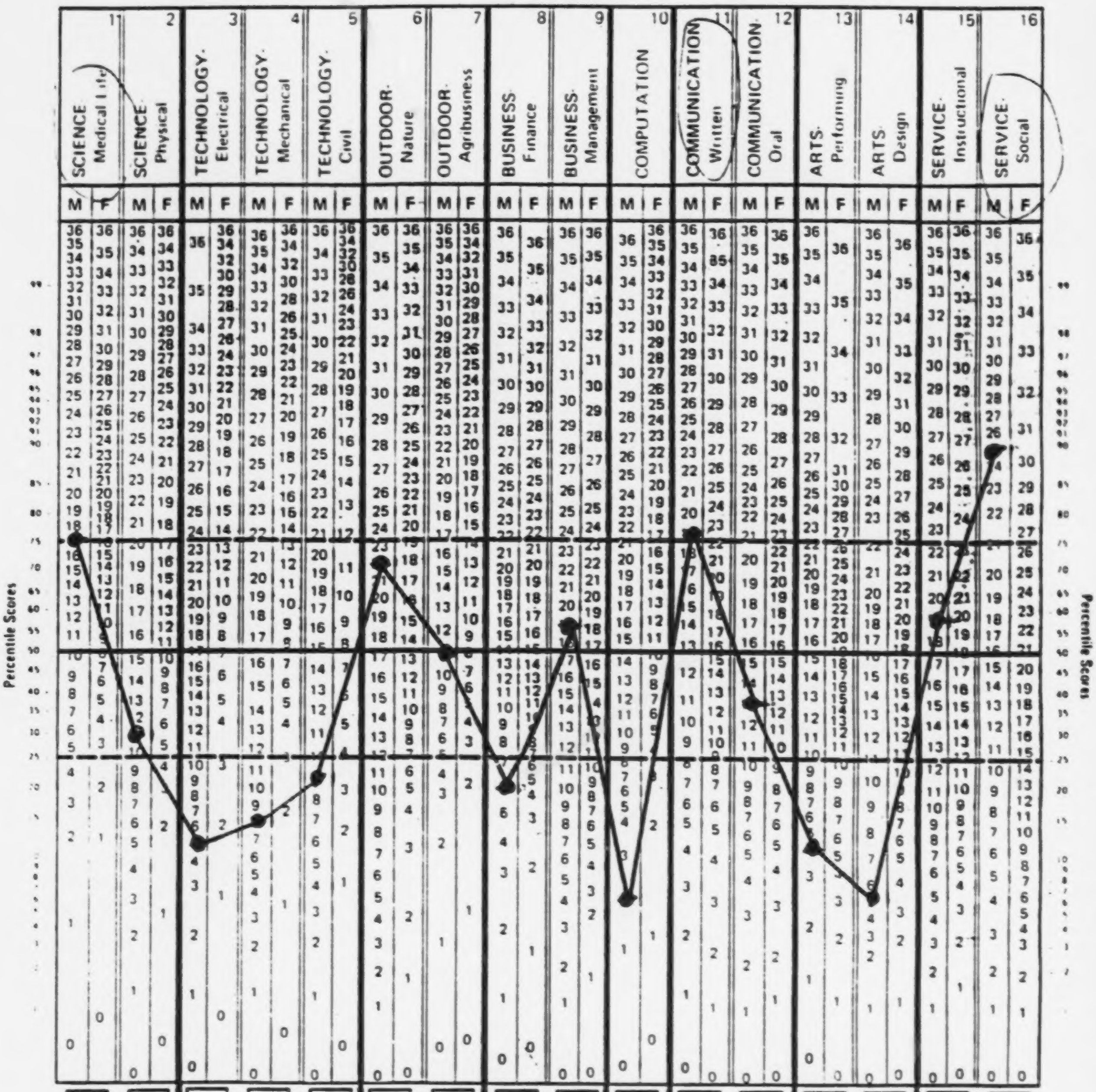
Introversion/Extroversion Scale: 61

Academic Comfort Scale: 30

Occupational Scales - none - mod./very similar
5 - similar - bus driver, funeral dir., social sci. teacher, speech pathologist

This is a copy of your COPS-P profile for your records. You may tear out this sheet and copy your profile from page 2. Be sure to print your name and fill out all the blanks on this sheet for your records.

SUMMARY PROFILE SHEET FOR THE COPS-P CAREER OCCUPATIONAL PREFERENCE SYSTEM — FILE COPY
COLLEGE



A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
17	11	5	8	9	22	11	6	19	2	19	13	4	5	19	25

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
INTERESTS 1	1 +	1	1	1	1	1	1	1	1	1	1 +	1	1	1	1	1 +
ABILITIES 2	2 +		2 +			2 −		2 +		2 +	2 +		2 +		2 +	
VALUES 3	a● ●c		a● b− ●e			b− ●c		d+ e● −f		a● e●	e● −f		f− −g		d+ −h	

NAME__________ __________ AGE 45 SEX M DATE 04-30-96

INSTITUTION or OCCUPATION PRAS GRADE or CLASS__________

PLEASE SEE THE BACK OF THIS SHEET.

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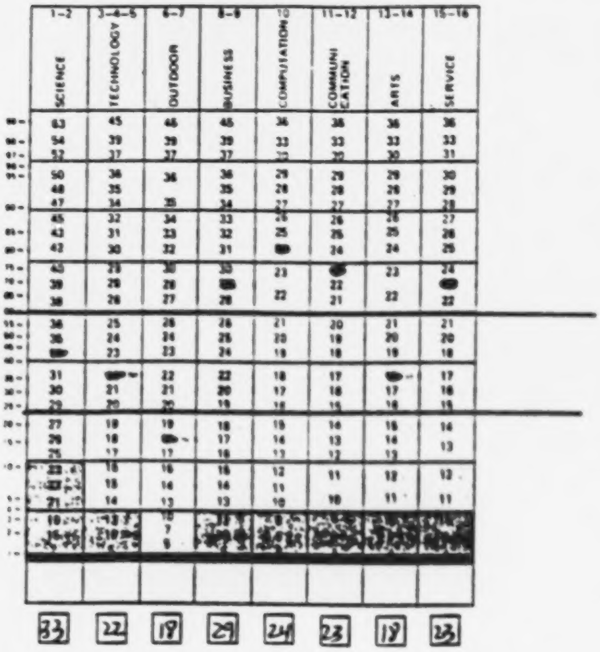
After completing Units (2) and (3) copy your CAPS scores below for your files.

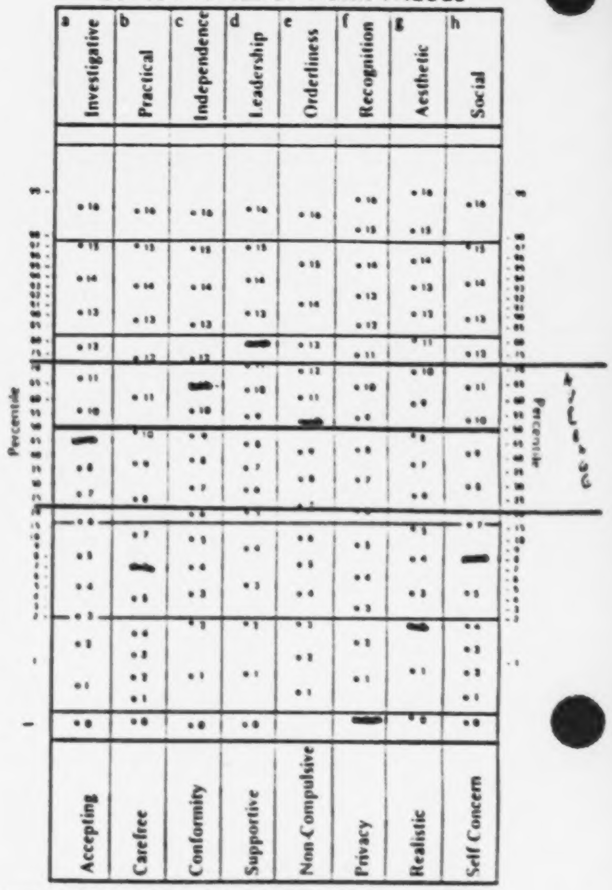
Copy your COPES scores from page 4.

CAPS CAREER PROFILE



1–2	3–4–5	6–7	8–9	10	11–12	13–14	15–16
SCIENCE	TECHNOLOGY	OUTDOOR	BUSINESS	COMPUTATION	COMMUNICATION	ARTS	SERVICE
33	22	18	29	24	23	18	23

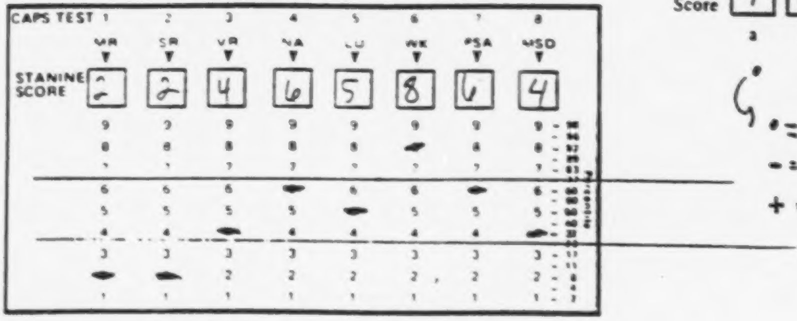
COPES PROFILE OF WORK VALUES



	a	b	c	d	e	f	g	h
	Investigative	Practical	Independence	Leadership	Orderliness	Recognition	Aesthetic	Social
	Accepting	Carefree	Conformity	Supportive	Non-Compulsive	Privacy	Realistic	Self Concern
Total Score	9	6	11	12	10	0	2	6
	a	b	c	d	e	f	g	h
	•	−	•	+	•	−	−	−

• = Average
− = Low
+ = High

CAPS ABILITY PROFILE



CAPS TEST	1	2	3	4	5	6	7	8
	MR	SR	VR	NA	LU	WK	PSA	MSD
STANINE SCORE	2	2	4	6	5	8	6	4

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STRONG INTEREST INVENTORY OF THE
STRONG VOCATIONAL INTEREST BLANKS

PAGE

PROFILE REPORT FOR:

ID:

AGE: 45 **SEX:** M

DATE TESTED: /30/96

DATE SCORED: 5/ 7/96

GOT	
R	Very Low
I	Mod. Low
A	Low
S	Average
E	Mod. Low
C	Very Low

SPECIAL SCALES: ACADEMIC COMFORT 30
INTROVERSION-EXTROVERSION 61

TOTAL RESPONSES: 324 **INFREQUENT RESPONSES:** 7

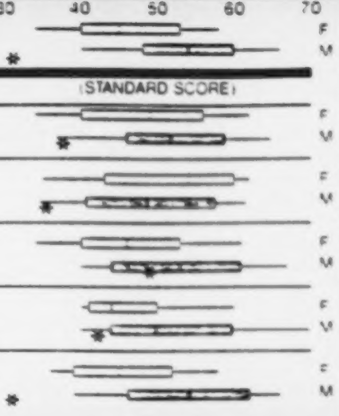
REALISTIC

GENERAL OCCUPATIONAL THEME - R

Very Low 31

BASIC INTEREST SCALES (STANDARD SCORE)

AGRICULTURE	Mod. Low	40
NATURE	Low	37
ADVENTURE	Average	49
MILITARY ACTIVITIES	Mod. Low	44
MECHANICAL ACTIVITIES	Very Low	32



OCCUPATIONAL SCALES

F	M		STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR	VERY SIMILAR
F	M				15	25	30		40	45	55
(CRS)	RC	Marine Corps enlisted personnel	(CRS)	23		*					
RC	RC	Navy enlisted personnel	33	21		*					
RC	RC	Army officer	34	27			*				
RI	RIC	Navy officer	33	11	*						
R	R	Air Force officer	30	17		*					
(C)	R	Air Force enlisted personnel	(C)	28			*				
R	R	Police officer	36	34				*			
R	R	Bus driver	32	42					*		
R	R	Horticultural worker	26	15		*					
RC	R	Farmer	31	35				*			
R	RCS	Vocational agriculture teacher	20	13	*						
RI	R	Forester	16	19		*					
(IR)	RI	Veterinarian	(IR)	29			*				
RIS	(SRI)	Athletic trainer	17	(SRI)							
RS	R	Emergency medical technician	41	37				*			
RI	RI	Radiologic technologist	37	32				*			
RI	R	Carpenter	18	8	*						
RI	R	Electrician	20	24		*					
RIA	(ARI)	Architect	12	(ARI)							
RI	RI	Engineer	15	16		*					

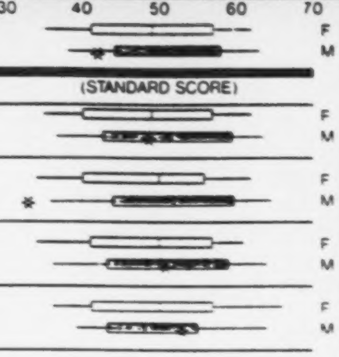
INVESTIGATIVE

GENERAL OCCUPATIONAL THEME - I

Mod. Low 43

BASIC INTEREST SCALES (STANDARD SCORE)

SCIENCE	Average	49
MATHEMATICS	Low	34
MEDICAL SCIENCE	Average	52
MEDICAL SERVICE	Mod. High	55



F	M		STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR	VERY SIMILAR
F	M				15	25	30		40	45	55
IRC	IRC	Computer programmer	33	29			*				
IRC	IRC	Systems analyst	31	16		*					
IRC	IR	Medical technologist	31	18		*					
IR	IR	R & D manager	24	14	*						
IR	IR	Geologist	22	32				*			
IR	(I)	Biologist	19	(I)							
IR	IR	Chemist	21	14	*						
IR	IR	Physicist	10	10	*						
IR	(RI)	Veterinarian	32	(RI)							
IRS	IR	Science teacher	21	25			*				
IRS	IRS	Physical therapist	37	29			*				
IR	IRS	Respiratory therapist	46	30				*			
IC	IR	Medical technician	38	22		*					
IC	IE	Pharmacist	45	38				*			
ISR	(CSE)	Dietitian	46	(CSE)							
(SI)	ISR	Nurse, RN	(SI)	33				*			
IR	I	Chiropractor	23	29			*				
IR	IR	Optometrist	37	27			*				
IR	IR	Dentist	27	22		*					
I	IA	Physician	31	25			*				
(IR)	I	Biologist	(IR)	30				*			
I	I	Mathematician	26	24		*					
IR	I	Geographer	44	30				*			
I	I	College professor	40	35				*			
IA	IA	Psychologist	34	33				*			
IA	IA	Sociologist	29	32				*			

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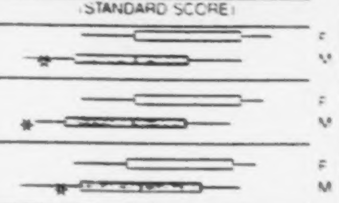
ARTISTIC

GENERAL OCCUPATIONAL THEME - A

Low 33

BASIC INTEREST SCALES (STANDARD SCORE)

MUSIC/DRAMATICS	Mod. Low	37
ART	Low	34
WRITING	Mod. Low	39



F	M		STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID-RANGE	MODERATELY SIMILAR	SIMILAR	VERY SIMILAR
F	M				15	25	30		40	45	55
AI	AI	Medical illustrator	8	2	*						
A	A	Art teacher	-21	12	*						
A	A	Artist, fine	26	25			*				
A	A	Artist, commercial	11	21		*					
AE	A	Interior decorator	-6	26			*				
(RIA)	ARI	Architect	(RIA)	15		*					
A	A	Photographer	31	22		*					
A	A	Musician	26	32				*			
AE	(EA)	Chef	25	(EA)							
(E)	AE	Beautician	(E)	23		*					
AE	A	Flight attendant	26	22		*					
A	A	Advertising executive	26	30				*			
A	A	Broadcaster	33	37				*			
A	A	Public relations director	13	25			*				
A	A	Lawyer	40	31				*			
A	AS	Public administrator	26	27			*				
A	A	Reporter	21	35				*			
A	A	Librarian	31	34				*			
AS	AS	English teacher	4	14	*						
(SA)	AS	Foreign language teacher	(SA)	23		*					

CPP

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7 1 OP7

STRONG INTEREST INVENTORY OF THE
STRONG VOCATIONAL INTEREST BLANKS

PROFILE REPORT FOR:

ID:

AGE: 45 **SEX:** M

DATE TESTED: /30/96

DATE SCORED: 5/ 7/96

SOCIAL

GENERAL OCCUPATIONAL THEME - S		
	Average	50

BASIC INTEREST SCALES	(STANDARD SCORE)	
TEACHING	Average	49
SOCIAL SERVICE	Mod. High	58
ATHLETICS	Average	58
DOMESTIC ARTS	Average	46
RELIGIOUS ACTIVITIES	Low	37

ENTERPRISING

GENERAL OCCUPATIONAL THEME - E		
	Mod. Low	43

BASIC INTEREST SCALES	(STANDARD SCORE)	
PUBLIC SPEAKING	Low	37
LAW/POLITICS	Average	54
MERCHANDISING	Average	44
SALES	Mod. Low	41
BUSINESS MANAGEMENT	Average	46

CONVENTIONAL

GENERAL OCCUPATIONAL THEME - C		
	Very Low	35

BASIC INTEREST SCALES	(STANDARD SCORE)	
OFFICE PRACTICES	Mod. Low	41

OCCUPATIONAL SCALES

F	M		STANDARD SCORES F	STANDARD SCORES M	VERY DISSIMILAR	DISSIMILAR	MODERATELY DISSIMILAR	MID RANGE	MODERATELY SIMILAR	SIMILAR	VERY SIMILAR
SOCIAL					15	25	30		40	45	55
SA	(AS)	Foreign language teacher	6	(AS)							
SA	SA	Minister	8	22		*					
SA	SA	Social worker	42	33				*			
S	S	Guidance counselor	20	30				*			
S	S	Social science teacher	27	41					*		
S	S	Elementary teacher	27	30				*			
S	S	Special education teacher	26	26			*				
SRI	SAR	Occupational therapist	32	26			*				
SIA	SAI	Speech pathologist	33	42					*		
SI	(ISR)	Nurse RN	35	(ISR)							
SCI	N/A	Dental hygienist	34	N/A							
SC	SC	Nurse LPN	29	40					*		
(RIS)	SR	Athletic trainer	(RIS)	35				*			
SR	SR	Physical education teacher	25	22		*					
SRE	SE	Recreation leader	28	31				*			
SE	SE	YWCA/YMCA director	38	26			*				
SEC	SCE	School administrator	26	24		*					
SCE	N/A	Home economics teacher	13	N/A							
ENTERPRISING					15	25	30		40	45	55
E	ES	Personnel director	23	25			*				
ES	E	Elected public official	23	26			*				
ES	ES	Life insurance agent	16	8	*						
EC	E	Chamber of Commerce executive	21	14	*						
EC	EC	Store manager	20	23		*					
N/A	ECR	Agribusiness manager	N/A	28			*				
EC	EC	Purchasing agent	25	22		*					
EC	E	Restaurant manager	20	31				*			
AR	EA	Chef	(AR)	27			*				
EC	E	Travel agent	16	36				*			
ECS	E	Funeral director	23	40					*		
CSE	ESC	Nursing home administrator	(CSE)	31				*			
EC	ER	Optician	28	35				*			
E	E	Realtor	9	18		*					
E	AE	Beautician	35	(AE)							
E	E	Florist	31	29			*				
EC	E	Buyer	14	24		*					
EI	EI	Marketing executive	24	36				*			
EIC	ECI	Investments manager	26	30				*			
CONVENTIONAL					15	25	30		40	45	55
C	C	Accountant	34	22		*					
C	C	Banker	38	22		*					
CE	CE	IRS agent	25	33				*			
CES	CES	Credit manager	23	27			*				
CES	CES	Business education teacher	15	12	*						
CSI	CES	Food service manager	(CS)	33				*			
(ISR)	CSE	Dietitian	(ISR)	35				*			
CSE	(ESC)	Nursing home administrator	23	(ESC)							
CSE	CSE	Executive housekeeper	27	25			*				
CS	(CES)	Food service manager	37	(CES)							
CS	N/A	Dental assistant	31	N/A							
C	N/A	Secretary	32	N/A							
C	R	Air Force enlisted personnel	35	[illegible]							
CRS	(RC)	Marine Corps enlisted personnel	31	(RC)							
CRS	CR	Army enlisted personnel	32	27			*				
CIR	CIR	Mathematics teacher	24	25			*				

ADMINISTRATIVE INDEXES (RESPONSE %)

BEST COPY AVAILABLE

OCCUPATIONS	8	L %	36	I %	56	D %		
SCHOOL SUBJECTS	11	L %	42	I %	47	D %		
ACTIVITIES	18	L %	41	I %	39	D %		
LEISURE ACTIVITIES	18	L %	46	I %	36	D %		
TYPES OF PEOPLE	25	L %	50	I %	25	D %		
PREFERENCES	30	L %	37	= %	33	R %		
CHARACTERISTICS	21	Y %	36	? %	43	N %		
ALL PARTS	15	%	40	%	45	%		

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The Choose-Get-Keep Model

Serving Severely Psychiatrically Disabled People

Karen S. Danley, Ph.D.
William A. Anthony, Ph.D.

Supported employment has emerged recently as a new service option in the field of developmental disability. Currently, a number of supported employment programs are being developed for people with long-term mental illness. Supported employment represents an expanded vision of what vocational services are possible for people with psychiatric disabilities. However, the "place-train" model of supported employment, which has become popular in developmental disability, must be replaced by a "choose-get-keep" model of supported employment for people with psychiatric disabilities. The critical concepts and programmatic implications of the choose-get-keep supported employment model are presented.

Supported employment, which, both as a concept and as a program, had its origins and growth in the field of developmental disability, is receiving increasing programmatic, legislative and fiscal support. At the same time, employment for people with psychiatric disabilities is receiving a lot of attention (Will, 1987). In March 1987, the Office of Special Education and Rehabilitative Services conducted a *State-of-the-Art Conference on Supported Employment for Individuals with Chronic Mental Illness* (Nolan, 1987). An entire issue of the *Psychosocial Rehabilitation Journal* has been devoted to the subject (Mellen & Danley, 1987), and data based articles are beginning to appear in the literature (Trotter, Minkoff, Harrison, & Hoops, 1988).

Anthony and Blanch (1987) overviewed the conceptual and legislative development of supported employment for people with psychiatric disabilities. They noted that in contrast to people with mental retardation, there was never an issue of "transition" from a comprehensive, mandated program (such as special education) into adult life. Rather, the major problem for people with psychiatric disabilities was an almost complete lack of any kind of vocational services.

Despite these historical differences, the concept of supported employment as emanating from the field of developmental disability is most applicable to people with psychiatric disability. Directly relevant is the notion of a goal of paid employment for all disabled people; integrated work settings; and ongoing support, including supervision, training or transportation (National Council on the Handicapped, 1986). Anthony and Blanch (1987) concluded that the basic assumptions and philosophy of supported employment cut across disability groups. The differences between supported employment for people with psychiatric disabilities and supported employment for people with developmental disabilities is at the operational level rather than the philosophical level. It is supported employment intervention itself and the principles underlying the intervention that are different.

Supported Employment Intervention Model

The supported employment model of intervention has been characterized as a *place-train* model rather than the more traditional *train-place* model of vocational rehabilitation (Twelfth Institute of Rehabilitation Issues, 1985). In the traditional, *train-place* model, a person was trained to "get ready" for competitive employment in such settings as day activity centers, day treatment centers and sheltered workshops, with the assumption that clients would move from such environments to competitive employment. However, it appears that people who have learned work relevant skills in these pre-competitive work environments can not easily transfer them to the competitive employment setting (Bellamy, Rhodes, & Albin, 1986).

The *place-train* model does not make this assumption about skill generalization. Rather, the client is placed in the competitive employment setting and the necessary skills are taught in that setting. The training occurs within a work environment that provides the intensity and length of support that each person needs to succeed. The *place-train* model of supported employment differs from the *train-place* model in a variety of ways, including underlying assumptions, philosophy, intervention strategies, level and length of support, opportunities for integration, and wages (Twelfth Institute on Rehabilitation Issues, 1985).

The Choose-Get-Keep Model of Supported Employment

In contrast to the *place-train* model of supported employment interventions for people who are developmentally disabled, people who are psychiatrically disabled need to be provided with a *choose-get-keep* model for supported employment interventions. The *choose-get-keep* model of psychiatric vocational services has been described by Anthony, Howell and Danley (1984). This service delivery model is particularly relevant to supported employment interventions. In essence, the *choose-get-keep* model of employment services, in its most basic form, helps people with psychiatric disabilities in their attempts at choosing, getting and keeping a job.

The *choose-get-keep* model posits that there are essentially three types or categories of competencies critical to a person's vocational success. A person can perform these competencies in the workplace and, depending upon a person's needs, with or without instruction and/or support. Examples of competencies related to each *choose-get-keep* category are listed in the accompanying table. The *choosing* phase culminates in the client's decision about the job in which he/she desires to work, and involves the client in evaluating the potential occupation and places of employment compatible with his/her personal needs and qualifications. The *getting* phase results in the client obtaining employment in a particular occupation at a particular place. In this phase, specific employers are located, contacted and interviewed. The *keeping* phase continues with the client maintaining his/her job for as long as he/she wishes. It involves the client applying the technical skills and work adjustment skills at the level needed to do the job. The supported employment intervention is an excellent example of this *choose-get-keep* model in operation.

Prior to the supported employment initiative, the psychiatric vocational rehabilitation approach, similar to the traditional approach used with people who are developmentally disabled, attempted to train people in job-keeping skills in nonpermanent and, at times, artificial employment settings, (*e.g.*, sheltered workshops, partial care centers, clubhouses, transitional employment placements). Essentially, people were trained in work adjustment skills before they obtained a permanent placement, similar to the traditional *train-place* model. In contrast, the supported employment model of *choose-get-keep* trains people in these skills after the person gets a permanent placement (more similar to the *place-train* approach of supported employment used for people with developmental disability). In this sense, the supported employment model of *place-train* is consistent with the *choose-get (place)-keep (train)* model of supported employment for people who are psychiatrically disabled.

Integral to the *choose-get-keep* model of supported employment is the concept of client choice.

However, there are a number of differences in conceptual and programmatic emphasis between the *choose-get-keep* model for people with psychiatric disabilities and the *place-train* model for people with psychiatric disabilities. *This is not meant to imply that the place-train model of supported employment might not also consider these concepts and programmatic issues to be critical.* However, as the supported employment approach becomes embedded into the psychiatric rehabilitation field, the conceptual and programmatic ingredients critical to its success need to be explicated.

Critical Conceptual Emphases

Choosing. Integral to the *choose-get-keep* model of supported employment is the concept of client choice. People who are psychiatrically disabled must have the opportunity to actively choose a job that is most compatible with their known interests, abilities, credentials, and background experience. Matching the person to the job is not done *to* him/her but *with* his/her participation. The choosing process is not a simple process of "obtaining information about a worker's skills and performance in order to make appropriate training decisions" (Bellamy, Horner, & Inman, 1979, p.89). A potential worker's likes, dislikes and career aspirations must also be identified and used as ingredients in a systematic decision-making process.

Unfortunately, most types of vocational programs for people with psychiatric disabilities have not allowed much choice. The field of mental health has emphasized neither client choice nor risk-taking in hospital and community settings. Furthermore, a history of failure has steered many people away from choosing and committing themselves to a particular course of action. Psychiatrically disabled people are often considered to be passive recipients of treatment programs, such as aftercare and day treatment, even though studies do show the usefulness of post-hospital treatment when it is willingly attended

(Anthony, *et al.*, 1978). Compounding the clients' problems with vocational choice are mental health and rehabilitation practitioners who sometimes limit themselves to standardized interest, aptitude or needs assessment tools or who recommend vocational options to clients based mainly on computerized profiles. This inattentiveness to the client's involvement in client decision making is not due to the client's disability, but rather to the failures of the mental health and rehabilitation system to actively involve the client in the process of choosing (Anthony, Howell, & Danley, 1984).

Unfortunately, most types of vocational programs for people with psychiatric disabilities have not allowed much choice.

Getting. In the getting phase of supported employment, people with psychiatric disabilities may wish to learn job seeking skills. Skills such as resume writing, filling out applications and interviewing for a job are skills which many people with psychiatric disabilities can master. Once again, learning and using these skills allows people with psychiatric disabilities to become more involved in *getting*, rather than being *placed* in, their supported employment position and to feel more prepared for future job changes and advancement possibilities.

Keeping. In the keeping phase of supported employment, emphasis must be placed on instructional interventions which focus on the *application* of appropriate job behaviors rather than the *acquisition* of these behaviors. Whereas persons with developmental disabilities might need more attention paid to acquiring new skills, many persons with psychiatric disabilities learn skills quickly or have existing skills which are difficult to apply in work settings. Problems arise in putting the skills into practice and sustaining the skills over time. Also, the focus of the instruction content of new skills is likely to be related to interpersonal and intrapersonal demands of the environment rather than demands associated with specific job tasks.

Understanding the model. The *choose-get-keep* model of supported employment describes a process that clients and family members can understand, and which can easily be explained to mental health professionals. While at first glance the traditional vocational rehabilitation process seems straightforward, there are now so many vocational assessment methods, intervention strategies and alternative vocational environments that clients, families and practitioners can become easily confused as to how each particular vocational service ingredient fits into the overall vocational picture (Danley and Rogers (1987). The *choose-get-keep* model enables everyone to know, at any given point in time, what is happening and why.

The *choose-get-keep* model enables everyone to know, at any given point in time, what is happening and why.

Other vocational experiences. An understanding of the vocational rehabilitation process is important because supported employment for people with psychiatric disabilities is but one of many vocational options for people who are psychiatrically disabled. Supported employment, even the *choose-get-keep* model, tends to emphasize the *get* and *keep* phases of the process. However, as Anthony and Blanch (1987) have cautioned, there are times when placement in a supported employment slot may be premature, particularly when the potential worker's occupational goals seem unclear or inappropriate:

"Career counseling and/or job placements designed to further the vocational exploration process might be necessary, not for the purpose of delaying the supported employment process, but for the purpose of starting anew the vocational development process. For persons with a psychiatric disability the vocational area is problematic not just because of the client's symptomatology, but also because the psychiatric disability and its treatment have impeded the client's personal and vocational development. Severely psychiatrically disabled clients are 'vocationally immature' because they lack many normal life experiences and life roles that are the foundation of one's vocational identity. As a result, their knowledge of themselves, including their own skill, interests and values in relation to the world of work is minimal; their ability to test the reality of self-knowledge against the demands of the working world is often deficient, and their general knowledge of the world of work is sparse" (Anthony and Blanch, 1987, p.7).

. The assumption of psychiatric vocational rehabilitation is that with increasing time and different vocational experiences, the clients' interests and values often change. Unfortunately, clients' occupational choices following the onset of the disability are oftentimes

Choose-Get-Keep Model

Examples of Work Related Competencies Categorized by the Three Supported Employee Phases

Choosing a Job	Getting a Job	Keeping a Job
Identifying own interests	Identifying job-related assets	Dressing appropriately for work
Identifying personal work capabilities	Identifying employment sources	Using public transportation
Matching personal traits to job requirements	Using sources of employment information	Reporting to work on time
Evaluating employment alternatives based on personal values	Writing a resume	Reporting to work regularly
Listing more than one employment alternative	Completing job applications	Interacting positively with supervisor
	Explaining work history gaps	Responding constructively to criticism
	Presenting self positively	Giving direction to others
	Demonstrating understanding of questions and statements	Sustaining work effort
	Dressing appropriately for interview	Evaluating own work performance
	Asking interview questions	Performing required job tasks. (cooking, typing, programming)
	Explaining career goals to an interviewer	
	Clarifying interviewer comments	

based on former values and skills rather than on a comprehensive picture of their current values and skills. It may in fact be desirable to create new occupational experiences, short of a supported vocational placement, to clarify interests and values. A common fallacy is that clients cannot develop new interests and values. The truth is that they *can* when they are stimulated by new knowledge gained first hand from relevant vocational experiences.

Programmatic Implications

The conceptual underpinnings of the *choose-get-keep* model of supported employment lead to certain programmatic emphases which may be more pronounced than in the *place-train* model of supported employment. The implications which follow are derived from the involvement of Boston University's Research and Training Center in the development and implementation of two supported employment projects based on the *choose-get-keep* model. One project has been operational for several years and data relevant to its operation has been reported in the literature (Trotter *et al.*, 1987); the other project is just beginning (Danley, 1987). The supported work project described by Trotter, *et al.* (1987) is called Access, and is operated by Transitional Employment Enterprises, Inc. (TEE), a private nonprofit agency. The other project (Danley, 1987) has been designed to use one site, a large urban university, as the location for a number of individual supported work placements.

Programmatically, to ensure that clients are given the opportunity to choose the job they wish to try, *the pre-employment phase of supported employment is typically longer than in the place-train supported employment model.* The TEE Access program has two pre-employment phases prior to the supported employment placement. The first phase has classes 3 hours a day, 5 days a week for 7 weeks. During this phase, the trainee identifies personal and work related values, interests and skills.

Entry into the second phase of pre-employment occurs when the trainee has identified occupational objective(s) compatible with their values, interest and skills. Programmatically, in addition to a lengthier pre-employment phase, *this also means that the jobs are developed by the job developer with some knowledge of the types of jobs in which the trainees might be interested.* Job development does not occur without an understanding of the uniqueness of each client's occupational choice.

The supported employment program must also have a programmatic response to those clients who wish to be involved in the placement process themselves. *Persons with psychiatric disabilities can be helped to be active participants in getting the job they want rather than feeling they have just been placed (dumped?) into a job the agency wants for them.* At TEE, the second phase of pre-employment, which may last from 1 week to several months, consists of 3 days of classes. During this period, TEE trainees are interviewing for jobs which the TEE job developer has found, or which they themselves have found using their own skills. The classes further refine the job seeking skills taught during the first pre-employment phase and provide peer support for the job getting effort.

The keeping phase of a supported employment program may be somewhat different than the training phase of the *place-train* supported employment model. Because clients learn skills quickly but may have difficulty using them, *job coaches need to spend time strategizing with the trainee about how to overcome the personal and environmental impediments to using what they already know more effectively and/or more often.* Rather than routinely providing onsite, intensive job skills training, the job coach would be more apt to act as a role model and provider of feedback to the trainee, as well as a liaison between the company supervisors and the trainee. Very importantly, the job coach is available to the trainee and the company by telephone on an as needed, continuous basis.

The simplicity and common sense nature of the *choose-get-keep* model of supported employment helps clients, families and practitioners understand the need for programmatic responses to all parts of the process. If the client can not choose the types of occupation in which he or she wants in a supported employment placement, then the supported employment program may try, in the pre-employment phase of supported employment, to provide the program components necessary to help trainees who cannot choose. These components might include values clarification procedures and instruction on decision making skills. Or the clients may be provided with more intensive career development experiences through some other program (*e.g.*, Kohn, Hutchinson & Unger, 1988). If trainees are still trying to choose whether they will work or not, independent of what occupation they want, then a clubhouse experience, transitional employment placement or volunteer position might be more appropriate at this time than a supported employment placement.

Vocational intervention models, other than supported employment, have been helpful to people with psychiatric disabilities. *A choose-get-keep model of supported employment recognizes within the model the potential contributions of other vocational interventions.* The *choose-get-keep* model of supported employment is an inclusive rather than exclusive model of services. Supported employment includes *choose-get-keep* program components but, when the supported employment program components are not sufficient for the client, it may be that other vocational interventions are more appropriate for a part of the *choose-get-keep* process. Program administrators of supported employment need to be aware of and conversant with the contributions to the client of other programs, such as transitional employment and clubhouse programs (Beard *et al.*, 1982), supported learning programs (Unger, 1988), intensive career development programs (Kohn, Hutchinson & Unger, 1988), and complementary mental health programs such as case management (Wayslenki *et al.*, 1985).

Summary

Supported employment, both as a concept and a program, is only as good as its outcome, *i.e.*, how well it increases the opportunities for people with psychiatric disabilities to be more successful and satisfied in their vocational area of functioning. It is not the answer, but it is an answer to an historical conceptual oversight and a programmatic void. The idea of a more immediate vocational placement with support for as long as the person needs has not been emphasized to the extent possible. As a result, programs based on these concepts have not been forthcoming. The *choose-get-keep* model of supported employment is consistent with the critical concepts of supported employment and can guide the supported employment programmatic responses which emerge.

Dr. Danley is Director, Supported Work Initiative, Center for Psychiatric Rehabilitation, Boston University; Dr. Anthony is Executive Director, Center for Psychiatric Rehabilitation.

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DATE ______ NAME ____________________

CAREER/LIFE PLAN

1. Work History

Place of Employment	Job Title	Dates

Major Responsibilities:

Place of Employment	Job Title	Dates

Major Responsibilities:

Place of Employment	Job Title	Dates

Major Responsibilities:

Place of Employment	Job Title	Dates

Major Responsibilities:

2. Educational History

a. High School	Diploma Cert.	Degree	year Attained	Major Field of Study
b. College or Technical School				
(1)				
(2)				
(3)				
c. Post Baccalaureate				
(1)				
(2)				
(3)				

3. List your most important achievements.

4. Identify the least successful or most distasteful experiences you have had in relation to your employment or education over the years.

5. What are your basic values? (philosophy of life)

6. Describe your idea of the "ideal" job.

7. List below your personal and professional skills.

8. What would you like most to accomplish?

What resources do you have and which do you need to accomplish this goal?

Have:

Need:

9. What is your ultimate life goal?

10. How do you plan (or hope) to get there? What is your personal operational plan?

PERSONAL INFORMATION FORM

This form provides an opportunity for you to describe yourself. Answer all questions that apply to you. Filling it out as completely as possible may make the counseling more useful to you. The detail provided ahead of time may save time in the counseling sessions.

Please bring the completed form with you at the next appointment. All information contained on the form will be kept in your file only and treated in strictest confidence.

Background Information

Name ____________________

Address ____________________

City ____________________ State ________ Zip Code ________

Home telephone: (____) ____________________ Office telephone: (____) ____________________
Area code/Number Area code/Number

If a student, give name and address of school ____________________

____

and your address and telephone number at school if it is different from the address above.

____

____

Date ____________________

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1. How did you hear of this service? ____________________

____

____

If through an individual, please give name: ____________________

2. Briefly state your reasons for seeking help. ____________________

____

____

3. What do you expect/hope will happen as a result of counseling assistance? ____________________

____

____

____

4. On the scale below, please estimate the severity of your problem by circling the appropriate number.

1	2	3	4	5
Mildly upsetting	Moderately severe	Severe	Very severe	Incapacitating

5. Have you ever been hospitalized for this or a related problem?

_____ No

_____ Yes. If yes, provide details below (name of hospital, dates, for what?). ____________________

____

____

____

____

____

____

____

____

____

____

____

____

PERSONAL AND FAMILY HISTORY

6. Your date of birth: ______________ Place of birth: ______________
month / day / year

7. Marital status. Circle appropriate number.

1	2	3	4	5	6
Never married	Married	Divorced	Separated	Widowed	Other, specify:

8. If married, how well do you and your wife/husband get along? Indicate by circling the most relevant description below.

1	2	3	4	5
Very well	Fairly well	Fair	Poor	Very unsatisfactorily

Comments: ______________

____

9. Number of children: ______________ Other dependents ______________

How many people live with you? ______________

10. Family members. Provide information on the form below for members of your immediate family at birth and and your family now (if any):

Family born into:

	Birthplace	Age (now or at death)	Education Completed	Occupation
Father's Name				
Mother's Name				
Sisters'/Brothers' Names				

Family now (if any):

Wife's/Husband's Name				
Children's Names				

HEALTH HISTORY

11. Height: ____________ Weight: ____________

12. How would you rate your general health. Circle the number of the most appropriate description.

1	2	3	4	5
Bad	Poor	Average	Good	Excellent

Comments: ____

____

13. Do you suffer from headaches or other pains?

_____ No

_____ Yes. If yes, please describe.

14. Do you wear glasses or contact lenses?

_____ No

_____ Yes. If yes, describe the status of your eyes and any trouble you have had with them in the past.

____

____

15. Do you wear a hearing aid?

_____ No

_____ Yes. If yes, describe the status of your hearing and any trouble you have had hearing in the past. If you are deaf, do you use sign language?

____

____

16. Have you any other physical limitations?

_____ No

_____ Yes. If yes, please describe. ________________________________

____

17. What serious childhood illnesses and diseases did you have? ____________________

____

____

____

18. What recent serious illnesses have you had? ______

19. Mention briefly any drug or alcohol history: ______

20. Have you ever had a serious illness or accident which kept you out of school or work for a month or more?

______ No

______ Yes. If yes, describe. ______

21. Have you had any unusual or mystical experiences?

______ No

______ Yes. If yes, what and when? ______

22. How many days did you miss from school or work during the past year due to health problems? ______

23. Have any members of your family or your spouse's family experienced any physical or emotional illnesses or mental retardation?

Father/Father-in-law ______

Mother/Mother-in-law ______

Sisters/Brothers ______

Wife/Husband ______

Children ______ ______

Others ______

24. Name any foods you particularly enjoy. ______

25. Name any foods you particularly dislike. ______

26. **Do you have any food allergies?**

______ **No**

______ **Yes. If yes, list them.** ______________________________

27. **Do you exercise on a regular basis?**

______ **No**

______ **Yes. If yes, describe the activity, e.g. jog, bike, row, walk, hike, etc.** ______________________________

____

____

EDUCATIONAL HISTORY

28. Schools attended.

	Name and Location of School	Dates Attended	Highest Grade/ Degree Completed	Name of Course/Degree
Elementary				
Junior High				
Senior High				
Trade/Business				
College/University				
Professional/Graduate				
Other				

29. a. What subjects do/did you like best? ______________________________

b. What subjects do/did you like least? ______________________________

c. In what subjects do/did you make the highest marks? ______________________________

d. In what subjects do/did you make the lowest marks? ______________________________

30. Final Marks of Last Term of Any Schooling (When was this?) ____________________

Marks of Present Term (Most Recent 19___ to 19___) ____________________

(applies only to those who are in school/college or planning to re-enter)

Name of Subject	Marks	Name of Subject	Marks
Math		Math	
Science		Science	
English		English	
History		History	
Other		Other	
Other		Other	

31. Have you ever taken any accelerated or advanced courses (including honors classes)?

______ No

______ Yes. If yes, what and where? ____________________

____

32. Did you ever skip a grade?

______ No

______ Yes

Did you ever repeat a grade?

______ No

______ Yes

If yes, what grade? ____________________

33. Did you fail any subjects? ____________________

______ No

______ Yes. If yes, what subject and what grade? ____________________

34. In what quarter of your class did you rank (1 is top quarter, 4 is lowest):

High school ________ Trade or other vocational school ________ College or university ________

35. Test scores.

a. Did you take the PSAT (Preliminary Scholastic Aptitude Test)?

______ No

______ Yes. If yes, when did you take it ____________________

Scores: Verbal ________ Mathematical ________

b. Did you take the SAT (Scholastic Aptitude Test)?

_____ No

_____ Yes. If yes, when did you take it? _____

Scores: Verbal _____ Mathematical _____

c. Did you take the ACT (American College Test)

_____ No

_____ Yes. If yes, when did you take it? _____

Score:

d. Did you take any other college aptitude test? Name _____

_____ No

_____ Yes. If yes, when did you take it? _____

Score:

e. Did you take any College Achievement Tests?

_____ No

_____ Yes. If yes, what and scores.

When _____ Subject _____ Score _____

f. Did you take the Graduate Record Examination?

_____ No

_____ Yes. If yes, score: _____

g. Did you take the Miller Analogies Test?

_____ No

_____ Yes. If yes, score: _____

36. Study habits. Where do you usually study? _____

Approximately how long each weekday? _____

What time do you start? _____ What time do you finish? _____

Describe the surroundings and circle all that apply.

1	2	3	4	5	6
Good space	Interrupted frequently	Quiet	Noisy	Study by myself	Study with others
7	8	9			
My bedroom	Library	Other School Building			

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Comments: _____

37. **Extracurricular activities. What groups, clubs, teams, offices, or other activities were you involved with while in high school or college? List both those associated with your school and community.**

High school years (school related) ______________________________

____

High school years (community related) ______________________________

____

College or other school years (school related) ______________________________

____

College or other school years (community related) ______________________________

____

38. Special training. Since leaving school, have you participated in any special educational programs (workshops, job training courses, correspondence study, or other programs?

_____ No

_____ Yes. If yes, what and where ______________________________

____

39. Summarize your educational background (include your strong and weak points, your areas of major study, etc.)

____

____

____

EDUCATIONAL PLANS

40. Do you plan to continue your education?

_____ No

_____ Yes. If yes, what level of education and what type of program? ______________________________

____

41. If you are interested in attending a college or university, what institution would you like to attend (if you could be accepted)?

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

What characteristic of these schools interests you the most? ______________________________

____

42. If you are interested in attending a trade or vocational school, what institutions (or type of programs) interest you the most?

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

Comments: ______________________

43. What are your educational preferences?

a. In what state or region would you like to attend school? ______________________

b. Do you prefer coed or single-sex institution? ______________________

c. Are you interested in a large, medium or small institution? ______________________

d. What major and minor subjects are you considering, if any? ______________________

e. Are you interested in graduate school? ______________________

44. Financial aid. How do you plan to finance advanced/additional education? Circle all that apply.

1 School financial aid

2 Federal/State financial aid

3 Family help

4 My own savings

5 Summer job earnings

6 Part-time work earnings

7 Bank educational loan

8 Other (specify) ____________

Comments: ______________________

WORK HISTORY

45. List all jobs you have held (list most recent experience first) including part-time and volunteer work; attach resume if available.

Type of Work	Employer	Dates Employed	Salary	Reason for Leaving

46. a. How did you get your present or last job?

b. How did you get your first job?

47. What kinds of work have you liked the most?

Liked the least or disliked?

48. a. Have you ever been fired or discharged from a job?

______ No

______ Yes. If yes, where and when

b. Have you left because you were to be fired?

_____ No

_____ Yes. If yes, where and when? ______________________________

____

49. What type of work situation do you prefer? Circle one below.

1	2	3	4
Alone	With others, but independent of them	In cooperation with others, as a team member	Doesn't matter

Comments: ______________________________

____

50. What kinds of things do you like to work with? Circle all applicable below.

1	2	3	4	5	6
People	Ideas	Things	Numbers	Words	Other, specify ________

51. Do some kinds of people annoy you on the job? These might be colleagues, subordinates, supervisors, or customers.

_____ No

_____ Yes. If yes, what types? ______________________________

52. Military service. Have you ever been in military service?

_____ No

_____ Yes. If yes, complete the items below.

Branch: ____________ Dates: ____________ Rank: ____________

Specialty: ______________________________

Describe duties, skills, etc. ______________________________

____

____

____

____

____

____

____

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CAREER PLANS

53. What is your present occupation? ______________________________

What is your career goal? ______________________________

54. List in the lefthand column below the occupations that your parents, spouse, friends, counselors, or others have suggested for you. Include any that you also contemplated for yourself. How do you feel about them now?

	Don't like	Might like	Like	No Opinion

Now, go to the righthand columns and check your reaction to each of these suggestions.

55. In what occupation or career do you see yourself working 10 years from now? Cite what you think you may be doing and, if different, what you would like to be doing.

Think I will be doing: ______________________________

Would really like to do: ______________________________

56. What are the things that you most want to find in a career/job? List specifics such as security, advancement opportunity, prestige, large earnings, etc.

SELF-EVALUATION

57. What kinds of things do you do well? Circle all applicable from the list below.

1 clerical
2 art/design
3 accounting work with figures
4 scientific/technical
5 public speaking/persuasion
6 writing
7 organizational activities
8 dramatics
9 selling ideas or products
10 physical work/manual labor
11 repetitious activities
12 new and varied tasks
13 supervising work of others
14 developing program plans
15 carrying out program plans
16 mechanical and repair
17 being your own boss
18 other, specify

58. Now, go over the above list again and mark an "X" over all items that you do not do well.

59. How would you characterize your personality. Circle all applicable from the list below.

1 Cheerful
2 Moody
3 Steady
4 Quiet
5 Talkative
6 Friendly
7 Reserved
8 Shy
9 Restless
10 Nervous
11 Calm
12 Irritable
13 Easily angered
14 Energetic
15 Seldom angry
16 Helpful
17 Outgoing
18 Affectionate
19 Quarrelsome
20 Stubborn
21 Timid
22 Lazy
23 Alert
24 Forgetful
25 Dependable
26 Consistent
27 Erratic
28 Conscientious
29 Unhappy
30 Often depressed
31 Tired
32 Humorous
33 Suspicious
34 Gullible
35 Cynical
36 Other, specify ______________

60. How would you describe yourself, using five words taken from above or elsewhere:

____

____

____

____

____

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PRIOR TESTING AND COUNSELING

61. Have you taken any psychological tests or had counseling before?

______ No

______ Yes. If yes, complete below.

When ______ Where ______ How Long ______ With Whom ______

Comments: ______

Name and address of psychologist or counselor ______

62. Specific tests taken ______

63. Unusual experiences. Please share any experiences out of the ordinary, whether positive or negative, that may be helpful in our working together:

LEISURE ACTIVITIES

64. What are your active hobbies and other special interests? ______

65. What hobbies and other special interests do other members of your family enjoy? ______

66. What books have you read recently (in the last 6 to 12 months)? ______

67. What magazines and newspapers do you read regularly? ______

68. Comment on your reading ability. ______

69. Have you recently (last year or so) studied or trained for anything outside of school (such as cabinet making, acting, music, art, sports lessons, cooking, etc.)?

______No

______Yes. If yes, what? ______

70. To what clubs or other organizations do you belong? If any officer, cite title. ______

71. Do you participate in or follow sports?

______No

______Yes. If yes, what sports and in what role? ______

72. Social activities. What are your usual social activities (with one or more other individuals)? ______

Comment on any social difficulties if they exist. ______

73. Is there any other information, special facts, or experiences you wish to share that you feel may be helpful to us in helping you?

74. What makes you unique? Discuss your assets and limitations as you see them.

75. How do you see yourself (a look in-depth at the real you)?

76. How do others see you?

ACHIEVEMENTS AND ASPIRATIONS

77. List your achievements:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________
14. ______________________
15. ______________________
16. ______________________
17. ______________________
18. ______________________
19. ______________________
20. ______________________
21. ______________________
22. ______________________
23. ______________________
24. ______________________
25. ______________________
26. ______________________

List your dreams and aspirations:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________
14. ______________________
15. ______________________
16. ______________________
17. ______________________
18. ______________________
19. ______________________
20. ______________________
21. ______________________
22. ______________________
23. ______________________
24. ______________________
25. ______________________
26. ______________________

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COUNSELING OBJECTIVES

78. Indicate the kind of help you are seeking by checking the appropriate items below:

______ Help with study concerns

______ Help with social concerns

______ Help with personal concerns

______ Help with life planning concerns

______ Help with time and stress management

______ Scholarships, fellowships, and loan information

______ Choosing a career

______ Need career information

______ Determining type of employment in relation to training and work experience

______ Determining type of employment in relation to interests, values, skills and personality

______ Help in getting a part-time job

______ Help in getting a summer job

______ Getting a job overseas

______ Learning about my skills

______ Job marketplace analysis

______ Changing career or job

______ Long-range occupational planning

______ Decision-making counseling

______ Resume counseling

______ Application counseling

______ Placement counseling

______ Interview counseling

______ Avocational counseling

______ Small business counseling

______ other: specify

FOR OFFICE USE ONLY

NAME ______________________________ PAGE ________

COUNSELING RECORD

DATE

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GOALS: SETTING AND ACHIEVING THEM

The following thoughts on goals deal with the importance of having them and offer suggestions on how to go about designing and achieving them. Experience has shown convincingly that those who have specific, written goals are far more likely to enjoy the success they envision than those who do not go beyond the wishing stage. As you go through these pages, please take sufficient time to pause, reflect, and undertake the exercises that are suggested, in sequence. Rushing through the steps or skipping about will diminish their value to you.

** WHAT WOULD YOU DO IF YOU KNEW YOU COULD NOT FAIL TO ACHIEVE IT?

At first, this may seem like a ridiculous question. However, when we realize that many of the limitations that seem to hold us back in life are self-imposed, the question becomes a challenge to us, asking us to overcome the tendency to stay in our comfort zones. In some ways, we are like thermostats; if we raise the set-point (our expectations for ourselves), we can raise our performance levels. We should not be willing to settle for the minimum that we are capable of doing.

** REVISIT YOUR SUCCESSES

A major responsibility we have, as adults, is to discover those areas where we have talents that we enjoy putting to good use and to channel our energies in those directions. As an indicator of your "areas of excellence", look back over your life up to this point and ask yourself which experiences gave you the greatest sense of satisfaction and self-worth? Please turn to Activity Page 1 and take time to answer the questions on that sheet. In these past "wins" are some of the seeds of your future satisfaction!

REVISIT YOUR SUCCESSES

As you think of past experiences and roles wherein you felt successful, try to extract the elements and factors that contributed to these feelings. These can be one-time or long-running episodes in your life. Use the back of the page if necessary.

EXPERIENCE	FACTOR
1.	
2.	
3.	
4.	

COMMON THREADS linking these successful experiences (list on reverse):

GOALS: ACTIVITY PAGE 1

** INVENTORY YOUR DREAMS

Now, please turn to Activity Page 2 and, in a free-form sort of way, continue by making a list of: things you would like to do or create in the future; people you would like to meet; places you would like to go; achievements you would like to accomplish; and "how you would like to be remembered when you're gone." This last question may seem odd, but by going through the exercise of writing your own memorial service "remembrance," you can continue the process of crystallizing your plans for your life, increasing the probability that your life will reflect the values that matter most to you.

INVENTORY YOUR DREAMS

THINGS YOU WOULD LIKE TO DO/CREATE:

PEOPLE YOU WOULD LIKE TO MEET:

PLACES YOU WOULD LIKE TO GO:

POSITIONS / ACHIEVEMENTS / HONORS YOU WOULD LIKE TO OBTAIN:

INVENTORY YOUR DREAMS, continued

HOW WOULD YOU LIKE TO BE REMEMBERED?

Here is the setting: years from now, family and friends are gathered to pay tribute to you at your memorial service. Before dying, you asked two people to speak on this occasion; one is your "Significant Other" in your personal life and the second is a friend and associate who worked with you for a number of years. You have the opportunity to "draft" their remarks - what would you like each one to say about you? (P.S. If either of them is long-winded, use the back of this page!).

SIGNIFICANT OTHER:

FRIEND FROM WORK:

GOALS: ACTIVITY PAGE 2b

** PICTURE THIS!!

You may have heard of the terms, "left-brained" and "right-brained." The two hemispheres of our brain, taken together, provide us with both our logical, rational outlooks and our feeling, creative talents. In addition to writing down our thoughts on our goals, it is beneficial to "visualize" our future success. On Activity Page 3, create a pictorial representation of whatever represents your goals - realized in the future.

PICTURE THIS!

On the reverse of this sheet, describe the elements in your picture and their significance.

GOALS: ACTIVITY PAGE 3

** GUIDELINES FOR FORMULATING WRITTEN GOALS

Before you continue in the process of setting your goals down in writing, consider these elements that influence the usefulness of this whole process to you:

1. Suggested formula for a written goal:

    a. State them in the positive. For example, I might say "I will weigh 175 pounds," as opposed to saying "I will lose 15 pounds."
    b. Be specific and mention the evidence you will experience when you attain the goal; example: "My B.A. degree from Pitt will hang proudly on my wall."
    c. Pursue goals that are attainable (within your control) and, where appropriate, maintainable over time.
    d. Go after goals that will have desirable consequences for both you and others.

2. Target when you expect to achieve these outcomes.

    a. Some of your goals will be near-term, some intermediate in their time-frame, and some will be long-range. If too many of your goals are bunched up in one of these "windows," you will need to consider spreading them out appropriately.

3. List the resources you can call upon.

   a. Potential resources include, but are not limited to:

      * Your faith
      * Your personal style and values
      * Friends, peers, role models
      * Education, formal and informal
      * Work experience
      * Money
      * Time

      As you will see on a subsequent form, you will be able to list potential resources for each of your goals.

4. Use models to help you.

   a. Think of and research people who have achieved success similar to that which you envision for yourself. Here are some activities you can consider:

      * Write down why you think they're successful
      * Write a "piece of advice" you think they would give you
      * Read a biography of them, if one exists
      * Even better, write and/or call them directly; ask to meet with them; if I were planning to become a surgeon, I would read The Puzzle People, then I would contact Dr. Starzl and ask if I could buy him a sandwich someday or tag along. Many successful people take a genuine interest in passing along their experience and offering encouragement.

5. Discipline: Are you willing to pay the price?

   a. This aspect is left out of many discussions on goals. Expect a certain amount of "pain" from discipline, but realize that it is preferable to the ultimate pain of regret over lost opportunity! As Dennis Waitley says, you don't want to live on "Someday Isle," as in "Someday, I'll get around to it." The Nike catch-phrase "JUST DO IT!" applies not only to our fitness plans, but to our entire range of goals!

6. Action is the critical ingredient.

   a. Not sure how or where to start? Sometimes a goal seems too imposing. Try this approach: Work backwards from your goal; that is, find a small chunk of activity that you can do today to advance you toward the goal's attainment. Also, don't think that all the important resources you need to make progress are "far away." The speaker Earl Nightingale tells a story called "Acres of Diamonds," about an African farmer who sought far and wide for riches, only to discover years later that the ground upon which his house stood was literally full of diamonds! Remember too, diamonds don't look like diamonds when they are in their rough form; they must be cut, shaped, polished, and placed in a beautiful setting, just like the opportunities that are right under our feet!

7. Failure - it's OK!

a. Failure is a prerequisite of success. Successful people have all overcome adversity. Literature is full of fascinating, true stories of "greats" who have risen above their failures. Abraham Lincoln, regarded as one of our finest Presidents, ran for political office nine times in his life and lost seven of those contests. Thomas Edison documented 10,000 failed efforts in his quest to invent the lightbulb.

b. Expect adversity. The more you try to accomplish in your life, the more you open yourself up to adversity. Don't expect smooth sailing. Hear what Dave Scott, a six-time winner of the Ironman Triathlon, has to say: "It's not the distance that overwhelms people who race Hawaii's Ironman Triathlon. It's the relentless wind that blows across the lava fields. You're on one of the highest ridges, you see miles of repetitive road to Hawi (sic), and you realize it's extremely hot and you're going straight into a 30-mile-an-hour crosswind. I've found that those who dwell on these conditions tend to fold. I always train for adversity. I consider adversity an asset, something to turn around to my advantage. One of life's most important lessons is learning to put your losses in perspective and to savor your triumphs by riding on euphoria's wave. Have high goals and expectations; regard defeats as stages on the road to success by remembering the little victories that have gotten you where you are."

from The Meaning of Life

8. Seek balance in your goals .

a. A blend of personal and professional goals will help you achieve both types of goals and increase your chances of satisfaction and fulfillment.

PERSONAL MISSION STATEMENT

If you have Covey's book, his section on developing your own personal mission statement is very helpful. In brief, this is the step of writing, succinctly, your statement of what you want your life to represent, what values drive and motivate you, where you draw your strength from, and the accomplishments you plan to achieve, in broad terms. Think of this as a telegram to yourself; words are precious and costly, yet you don't want to leave out any essentials. In a paragraph or two, summarize these elements. Refer back to the picture you drew previously. Make a draft, come back to it and make revisions until you are comfortable. Even then, remember that this can be changed and up-dated by you at any time in the future. Life demands flexibility; your mission statement and goals don't have to be set in stone. The person who takes these steps is able to modify them to reflect reality and factors that change.

Proceed to Activity Page 4 and work on your Mission Statement.

MY PERSONAL MISSION STATEMENT

"MY GOALS"

You are now ready to list specific goals in various areas of your life. On Activity Page 5, a number of suggested areas have been provided: Career, Family, Finances, etc. You may use these or you can modify this list to suit your needs; do not feel constrained by what you see on this page.

Here are some clarifying thought on some of the categories listed:

* Education refers both to formal programs (like an MBA) and to informal objectives (such as learning Sign Language or learning to play the piano). Each of us has an increasing responsibility for our own lifelong learning curve.

* Finances refers not only to income projections, but also to the ways you will manage and use your monetary assets. Preparing for your "retirement" years is a valid part of this area.

* Health should include both mental (example: "read a minimum of one book each month") and physical aspects (example: do three aerobic workout each week"). Keeping up with some form of regular exercise is critical in both spheres. This is also the category in which dietary goals can logically be placed.

* Activities is the place to list those one-time experiences that you would like to have. This is the "FUN" category, where you can list such things as: "Ski in Colorado; take a rafting trip through the Grand Canyon; ride in a hot air balloon; take a Bed-and-Breakfast tour of England, etc. By all means, don't stop at 15; Lou Holtz, the Notre Dame football coach at one time created a list of more than 100 such goals, and proceeded to accomplish every one, including having dinner at the White House. He probably has a new list he's working on!

MY GOALS

Date: ____________

A. CAREER
1.
2.
3.
4.
5.

B. FAMILY
1.
2.
3.
4.
5.

C.FINANCES
1.
2.
3.
4.
5.

D. EDUCATION
1.
2.
3.
4.
5.

E. PUBLIC SERVICE
1.
2.
3.
4.
5.

GOALS:ACTIVITY PAGE 5a.

MY GOALS, continued

F. HEALTH

1.
2.
3.
4.
5.

G. ACTIVITIES

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

"Whatever you vividly imagine, ardently desire, sincerely believe, and enthusiastically act upon...must inevitably come to pass!

GOALS: ACTIVITY PAGE 5b.

THE ACTION PLAN

All that has happened to this point would be an empty exercise if we fail to apply specific plans to allow us to implement the goals we have established. The action plan on Activity Page 6 is designed to allow you to do just that. The intent is that, on an annual basis at least, you will review your "My Goals" list, assess your current status with respect to each, and devise a specific plan for the coming year to address those goals that you feel are sufficient priorities to act upon in the year ahead. Remember that some goals will be deferred until later.

* You will want to make a number of copies of this form before proceeding.

* Follow the numbering system from the "My Goals" pages. If goal #F1 is "To do three aerobic workouts weekly," devote one "Action Plan" page to that specific goal and fill out the boxes accordingly.

* Under "Action Steps/Desired Results," state the desired outcomes in specific, positive terms. List the steps in sequence, either first-step-to-last or in reverse order, if that helps you think it through.

* "Resources Needed" can include money, materials, people's help, or anything else beyond your own time.

* "Responsibility" lists those people - yourself and/or others - upon whom the completion of that step depends.

* "Timetable" should include both a target starting date and a target completion date.

* "Success Rating": Goals should be measurable. Here, you can apply your own evaluation system; I would suggest that "O" represents "not done at all'" and "5" stands for "completed as planned." Fill in this column at the end of the year.

GOALS: ACTION PLAN FOR THE YEAR: _ _ _ _ _ _

Goal # ________ Goal: ____

____

ACTION STEPS/DESIRED RESULTS	RESOURCES NEEDED	RESPONSIBILITY	TIMETABLE	SUCCESS RATING 0 - 5

"A goal without a plan is just a dream!"

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GOALS: ACTION PLAN FOR THE YEAR: ______

Goal # ________ Goal: ____

____

ACTION STEPS/DESIRED RESULTS	RESOURCES NEEDED	RESPONSIBILITY	TIMETABLE	SUCCESS RATING 0 - 5

"A goal without a plan is just a dream!"

EDUCATION/TRAINING OPTION

STUDENT FINANCIAL AID KIT

PHEAA
Creating Access to Education

1995 FALL WORKSHOPS FOR GUIDANCE COUNSELORS

PHEAA PRESENTATION
9:00 to 9:40
&
10:45 to 11:25

AGENDA NOTES

(Provided as a handout at the 1995 Guidance Counselor Workshop Series)

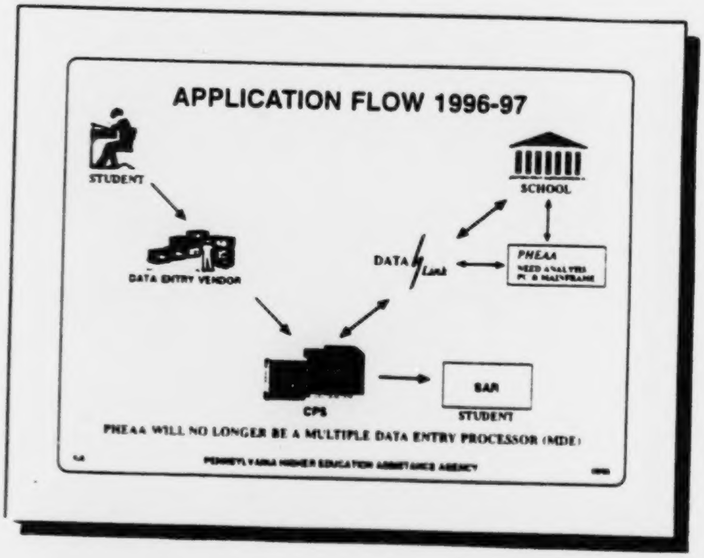
1839

Pennsylvania Higher Education Assistance Agency
1200 North Seventh Street • Harrisburg, Pennsylvania 17102-1444

I. PHEAA Update:

A. Application Flow

1. Student completes FAFSA and mails to Data Entry Vendor.
2. Data Entry Vendor will forward data to Central Processor.
3. Central Processor will print and mail a SAR acknowledgement to the student who files electronically. Students filing a paper FAFSA will still receive a paper SAR.
4. PHEAA will receive application data from the Central Processor.
5. PHEAA will transmit the data to schools using PHEAA as their EDE Destination Point.


STUDENT
SCHOOL
DATA ENTRY VENDOR
DATA Link
PHEAA
NEED ANALYSIS
PC & MAINFRAME
CPS
SAR
STUDENT

APPLICATION FLOW 1996-97

PHEAA WILL NO LONGER BE A MULTIPLE DATA ENTRY PROCESSOR (MDE)

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY

B. State Grant

1. Maximum award increased to $2,632/year for full-time students and increased to $1,316/year for part-time students.
2. PHEAA adjusted maximum income cutoff has been increased to $60,000 for BOTH full-time and part-time students.
3. Need covered by grant increased to 40%.
4. Parents contribution reduced approximately 4%.
5. Percentage of reduction based on income: The income level at which such reduction occurs has been increased by $5,000.

1841

C. Federal Family Education Loan Program Update:

1. Interest Rates - July 1, 1995 to June 30, 1996

    a. Stafford Loans - 8.25%

    b. PLUS Loans - 8.98%

2. Guaranty Fee - PLUS Loans

    a. Capped at the lesser of 1% of the loan disbursement or $50

3. PHEAA Keystone Stafford Loan Program - low cost Stafford Loans

    a. Eligibility requirements: (Must meet all.)

        - eligible PA State Grant applicant
        - family income less than $21,000
        - enrolled in program of study at school eligible for the State Grant Program
        - meet PA residency requirements for the grant program

    b. Same as regular Stafford Loan except:

        - fees reduced from 4% to 2%
        - interest rate reduced by 1% after making 36 on-time monthly payments

    c. PHEAA will offer a Keystone Stafford Loan to those applicants who file the regular Stafford application or who requests an application via the FAFSA.

D. Paul Douglas Scholarships

1. No awards for 1995-96
2. Applies to new awards as well as renewals.

1843

II. Free Application For Federal Student Aid (FAFSA) Updates:

NOTES:

III. PHEAA Basics (State Grant) 1-800-692-7435

1. Application Process:

   File "Free Application for Federal Student Aid".

2. Deadlines:

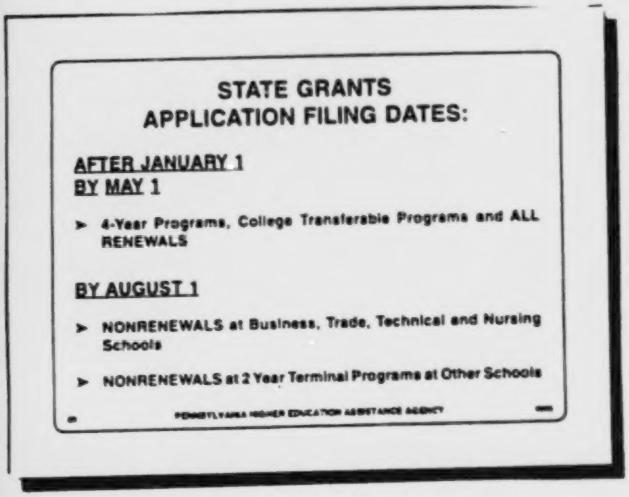
   File after January 1.

   5/1 - All renewal applications; and all non-renewal applications who plan to enroll in baccalaureate degree programs and college transfer programs.

   8/1 - Non-renewal applications who plan to enroll in business, trade, or technical schools, hospital schools of nursing, or two year terminal programs at four year colleges, two year public or junior colleges.

   Note: A renewal student is one who was the recipient of a PHEAA State Grant in the prior academic year.

   Late applications are processed on a funds available basis. All students should be encouraged to apply, even though the deadline may have passed.



STATE GRANTS
APPLICATION FILING DATES:

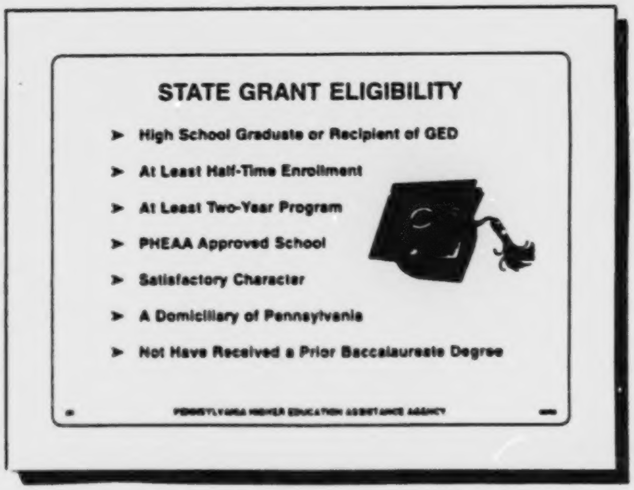
AFTER JANUARY 1
BY MAY 1

- 4-Year Programs, College Transferable Programs and ALL RENEWALS

BY AUGUST 1

- NONRENEWALS at Business, Trade, Technical and Nursing Schools
- NONRENEWALS at 2 Year Terminal Programs at Other Schools

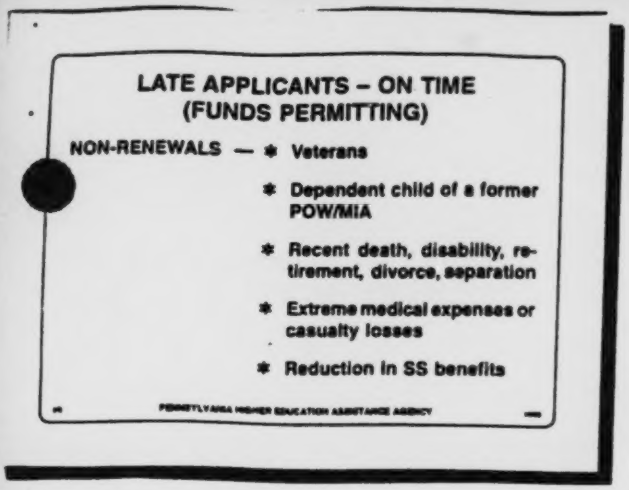
PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



STATE GRANT ELIGIBILITY

- High School Graduate or Recipient of GED
- At Least Half-Time Enrollment
- At Least Two-Year Program
- PHEAA Approved School
- Satisfactory Character
- A Domiciliary of Pennsylvania
- Not Have Received a Prior Baccalaureate Degree

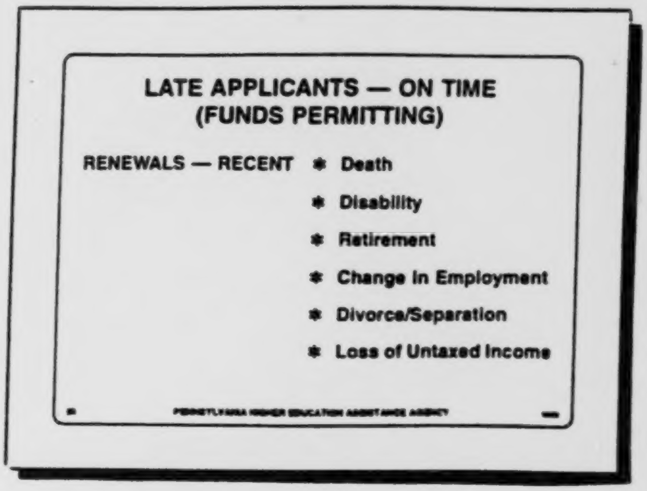
PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



LATE APPLICANTS – ON TIME (FUNDS PERMITTING)

NON-RENEWALS —
- ✱ Veterans
- ✱ Dependent child of a former POW/MIA
- ✱ Recent death, disability, retirement, divorce, separation
- ✱ Extreme medical expenses or casualty losses
- ✱ Reduction in SS benefits

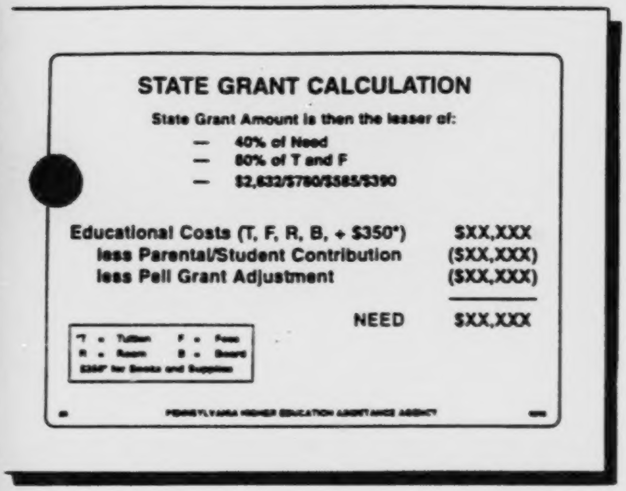
PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



LATE APPLICANTS — ON TIME (FUNDS PERMITTING)

RENEWALS — RECENT
- ✱ Death
- ✱ Disability
- ✱ Retirement
- ✱ Change in Employment
- ✱ Divorce/Separation
- ✱ Loss of Untaxed Income

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



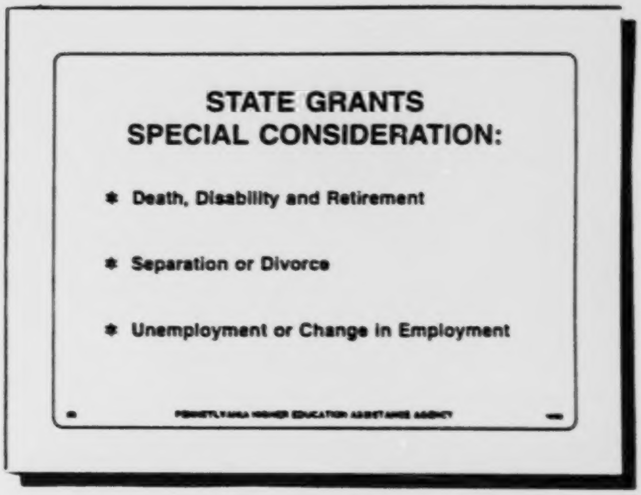
STATE GRANT CALCULATION

State Grant Amount is then the lesser of:
- — 40% of Need
- — 80% of T and F
- — $2,632/$780/$585/$390

Educational Costs (T, F, R, B, + $350*)	$XX,XXX
less Parental/Student Contribution	($XX,XXX)
less Pell Grant Adjustment	($XX,XXX)
NEED	$XX,XXX

*T = Tuition F = Fees
R = Room B = Board
$350* for Books and Supplies

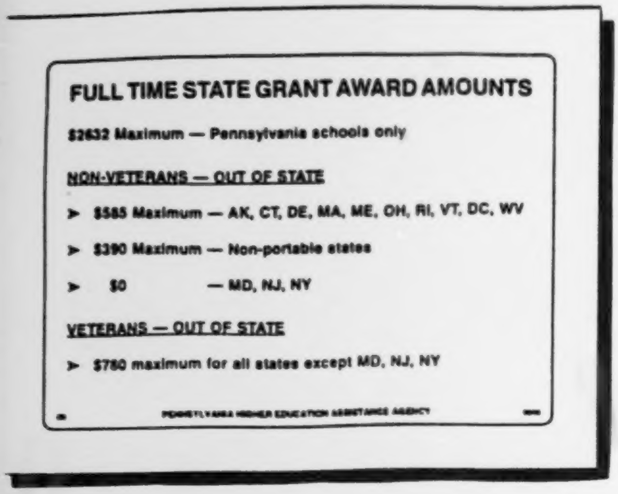
PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



STATE GRANTS SPECIAL CONSIDERATION:

- ✱ Death, Disability and Retirement
- ✱ Separation or Divorce
- ✱ Unemployment or Change in Employment

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



FULL TIME STATE GRANT AWARD AMOUNTS

$2632 Maximum — Pennsylvania schools only

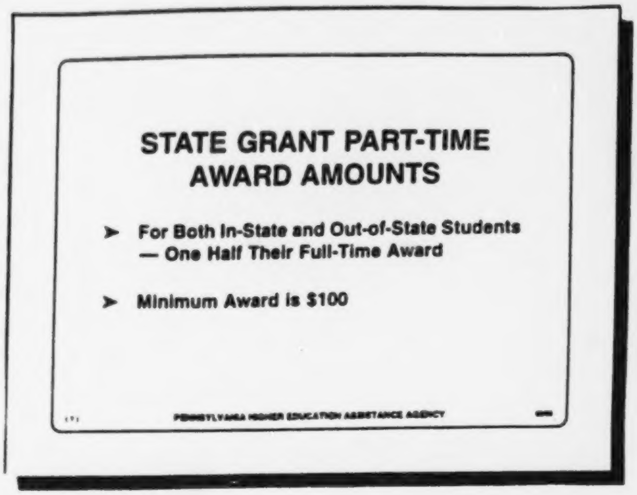
NON-VETERANS — OUT OF STATE

- ➤ $585 Maximum — AK, CT, DE, MA, ME, OH, RI, VT, DC, WV
- ➤ $390 Maximum — Non-portable states
- ➤ $0 — MD, NJ, NY

VETERANS — OUT OF STATE

- ➤ $780 maximum for all states except MD, NJ, NY

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



STATE GRANT PART-TIME AWARD AMOUNTS

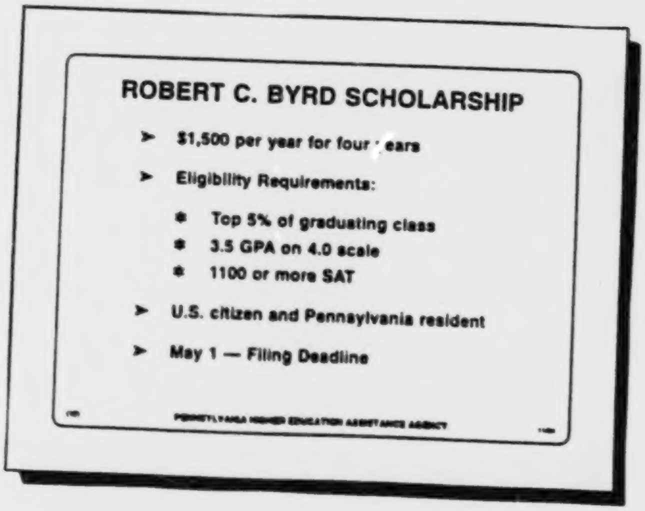
- ➤ For Both In-State and Out-of-State Students — One Half Their Full-Time Award
- ➤ Minimum Award is $100

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY

III. Review of PHEAA State Grant (continued)

IV. 1996-97 Robert C. Byrd Scholarship

1. Annual award of $1,500; federally funded. Four years of eligibility.
2. Minimum criteria required for consideration:
    a. PA residency
    b. Meet federal government citizenship requirements
    c. Must meet "all" three educational standards:
        * In top 5% of high school class
        * Have a 3.5 grad point average on a 4.0 scale
        * SAT scores of 1100 or more; ACT composite score of 27 or more; or GED score of 289 or above
3. Meeting the criteria does not guarantee selection: at least two recipients will be chosen in each county by lottery.
4. Deadline date for applications is May 1.
5. Recipients' checks are mailed directly to the students. Students must take check to school.



ROBERT C. BYRD SCHOLARSHIP

- ➤ $1,500 per year for four years
- ➤ Eligibility Requirements:
    - * Top 5% of graduating class
    - * 3.5 GPA on 4.0 scale
    - * 1100 or more SAT
- ➤ U.S. citizen and Pennsylvania resident
- ➤ May 1 — Filing Deadline

V. 1996-97 Agricultural Education Loan Forgiveness Program (AELF)

General:

The Agriculture Education Loan Forgiveness Program was created by the Pennsylvania General Assembly and signed into law by Governor Casey in 1992. It is intended to:

1. Assist student loan borrowers who receive degrees in fields related to the production of agricultural products so they can return to work on family farms or family farm corporations.
2. Assist students who receive degrees in veterinary medicine and who subsequently practice veterinary medicine a portion of which must include farm animals.

Requirements:

1. All such borrowers must have graduated from a Pennsylvania institution of higher education and be in their first year of full-time employment on a family farm, or a "family farm corporation" as defined in the law, or in the practices of veterinary medicine including farm animals on or after July 1, 1991.
2. In addition, veterinarians must be accredited by the U.S.D.A. to perform accredited tasks in Pennsylvania including the signing of animal health certificates required for interstate commerce in animals and animal products and be able to certify regulatory testing of agricultural animals such as testing for bovine tuberculosis or brucellosis.

Eligible Loans:

Loans made or guaranteed by PHEAA, the Pennsylvania Higher Education Assistance Agency. Other loans whether private or personal are not eligible.

Amounts:

The program may repay as much as $2,000 per year for eligible applicants and up to $10,000 for any one applicant, in effect a "lifetime maximum". Actual payments will be limited by the number of eligible applicants and the amount appropriated by the General Assembly.

Applications:

Applications may be obtained from PHEAA, the Pennsylvania Higher Education Assistance Agency. Write to: PHEAA Agriculture Education Loan Forgiveness Program, P.O. Box 8114, Harrisburg, Pennsylvania, 17105-8114. Or call: (717) 257-5220.

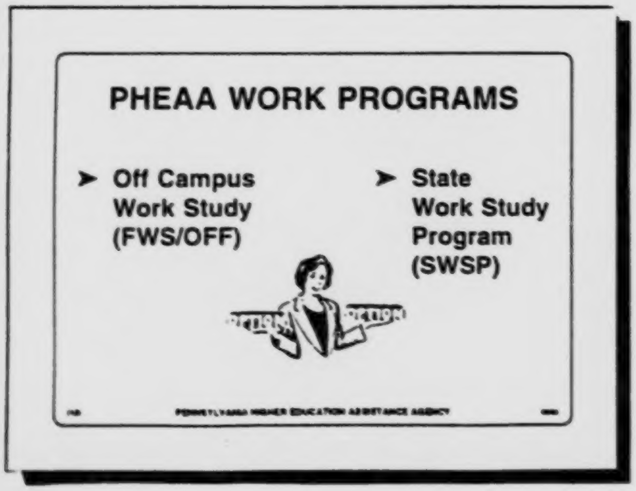
VI. 1996-97 Work-Study Programs (717) 720-2550

1. Off-Campus Work-Study Programs

   - Cooperative effort of PHEAA, participating post-secondary schools and non-profit employers
   - Student must be eligible Pennsylvania resident and be eligible for the Federal College Work-Study Program
   - Applications and information available in the Financial Aid Office
   - Rate of pay determined by Financial Aid Office

2. State Work-Study Programs

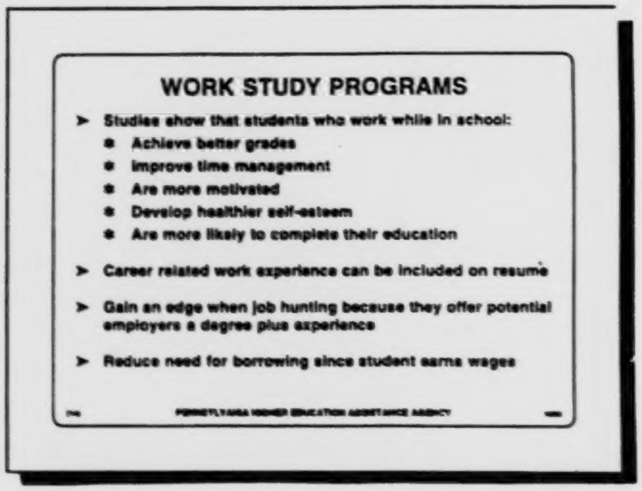
   - Cooperative effort of PHEAA, participating post-secondary schools and employers
   - Employer is not required to be "non-profit"
   - Jobs are available in high tech and community service
   - Information and applications available from PHEAA or the Financial Aid Office



PHEAA WORK PROGRAMS

➤ Off Campus
Work Study
(FWS/OFF)

➤ State
Work Study
Program
(SWSP)



WORK STUDY PROGRAMS

➤ Studies show that students who work while in school:
  - Achieve better grades
  - Improve time management
  - Are more motivated
  - Develop healthier self-esteem
  - Are more likely to complete their education

➤ Career related work experience can be included on resumé

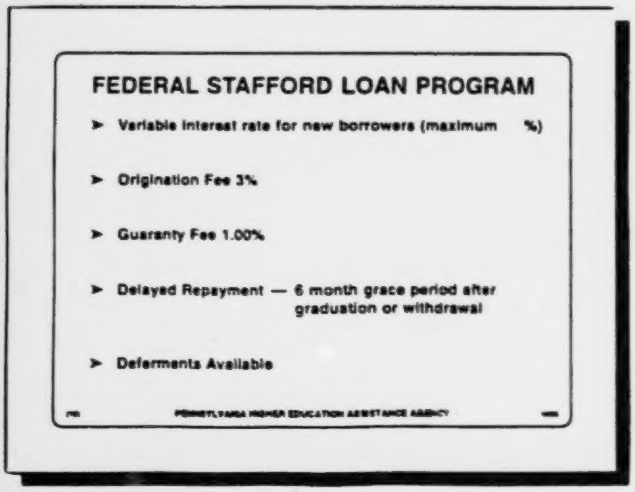
➤ Gain an edge when job hunting because they offer potential employers a degree plus experience

➤ Reduce need for borrowing since student earns wages

VII. 1996-97 Federal Stafford Loan (Subsidized/Unsubsidized) 1-800-692-7392

1. Annual Loan Limits:	(A) Subsidized/ Unsubsidized Loan	(B) AdditionalUnsubsidized Eligibility for Independent Student*
1st Year Undergraduates		
Full Academic Year	$2,625	$4,000
⅔ Academic Year	$1,750	$2,500
⅓ Academic Year	$ 875	$1,500
2nd Year Undergraduates		
Full Academic Year	$3,500	$4,000
⅔ Academic Year	Prorated	$2,500
⅓ Academic Year	Prorated	$1,500
3rd, 4th, or 5th Year Undergraduate		
Full Academic Year	$5,500	$5,000
Less Than Full Academic Year	Prorated	Prorated
Graduate/Professional Student	$8500	$10,000

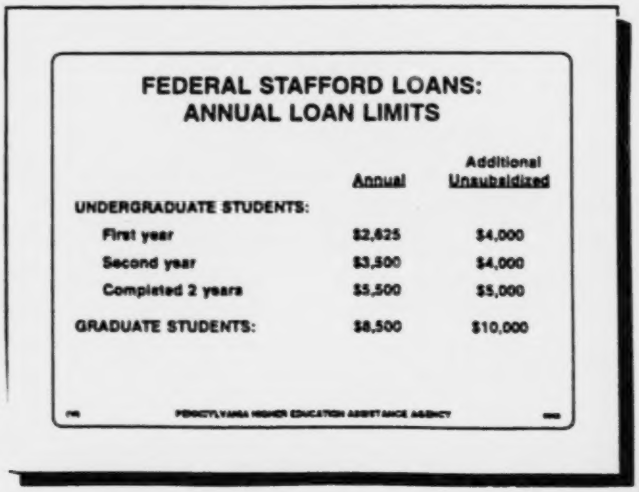
*Graduate, independent or dependent students whose parents have been denied a PLUS Loan.



FEDERAL STAFFORD LOAN PROGRAM

- ➤ Variable interest rate for new borrowers (maximum %)
- ➤ Origination Fee 3%
- ➤ Guaranty Fee 1.00%
- ➤ Delayed Repayment — 6 month grace period after graduation or withdrawal
- ➤ Deferments Available

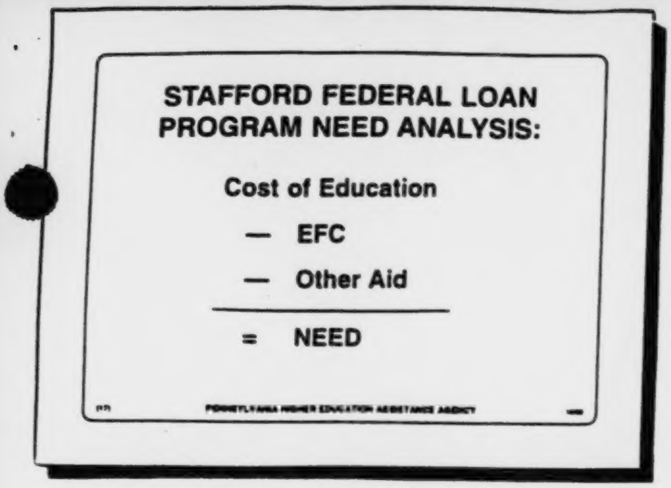
PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



FEDERAL STAFFORD LOANS: ANNUAL LOAN LIMITS

	Annual	Additional Unsubsidized
UNDERGRADUATE STUDENTS:		
First year	$2,625	$4,000
Second year	$3,500	$4,000
Completed 2 years	$5,500	$5,000
GRADUATE STUDENTS:	$8,500	$10,000

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



STAFFORD FEDERAL LOAN PROGRAM NEED ANALYSIS:

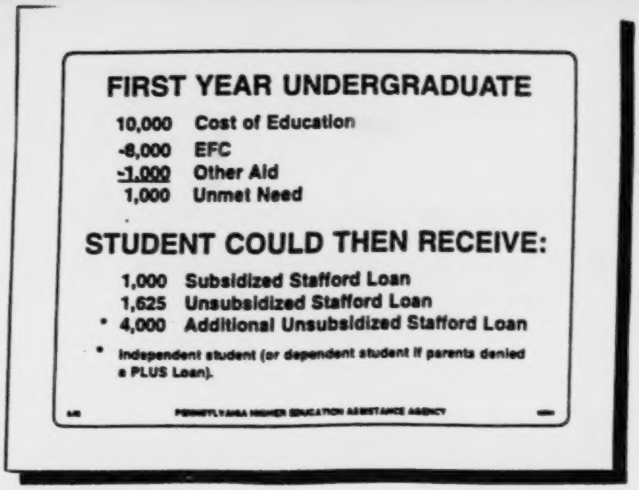
Cost of Education

— EFC

— Other Aid

= NEED

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY



FIRST YEAR UNDERGRADUATE

10,000	Cost of Education
-8,000	EFC
-1,000	Other Aid
1,000	Unmet Need

STUDENT COULD THEN RECEIVE:

1,000	Subsidized Stafford Loan
1,625	Unsubsidized Stafford Loan
• 4,000	Additional Unsubsidized Stafford Loan

• Independent student (or dependent student if parents denied a PLUS Loan).

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY

2. Variable interest rate for new borrowers - maximum 8.25%

Following is a summary for each Stafford Loan type (subsidized and unsubsidized) of how the student's grade level and prior loan borrowings for the same academic year are to be taken into account when determining the actual loan amount that applies to the student whose loan application is being certified:

a. A subsidized Stafford Loan amount for a dependent student is determined as the lesser of:

   (1) Cost minus aid minus, EFC; or
   (2) Appropriate academic grade level limit, minus any Stafford Loan amounts (subsidized or unsubsidized) received by the student in the same academic year.

b. An unsubsidized Stafford Loan amount for a dependent student is determined as the lesser of:

   (1) Cost minus aid minus subsidized Stafford Loan amount determined in "a"; or
   (2) Appropriate academic grade level limit, minus any Stafford Loan amount (subsidized or unsubsidized) received by the student in the same academic year, including the subsidized stafford loan determined in "a".

Note: Student must file a need analysis (FAFSA) application in addition to the actual Stafford Loan Application.

3. Applications can be requested through the PHEAA State Grant Application, or from lenders participating in the program.

VIII. 1996-97 Federal Parent Loans for Undergraduate Students (PLUS) 1-800-692-7392

1. The PLUS Program currently has no annual or aggregate limits. Loans can be guaranteed up to the difference between educational costs minus other financial aid.

   * Parent(s) for dependent student

2. Variable interest rate; changes each July 1st; maximum rate is 9%.

3. Analysis required:

   Cost of Education
   - Other Financial Aid
   = Need for PLUS Loan

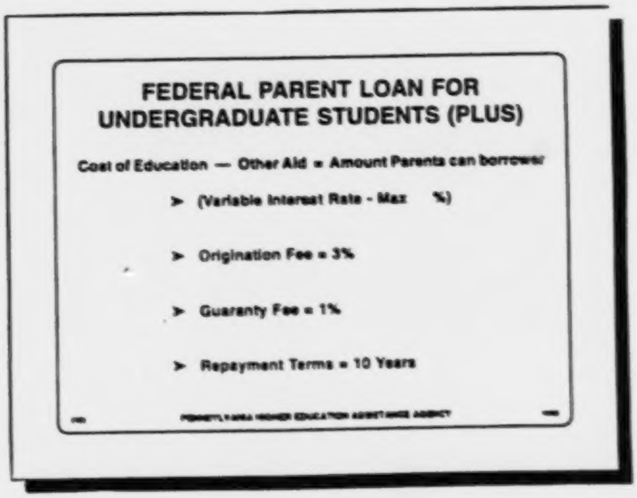
Note: Expected Family Contribution is not a factor in this program.

4. Financial Charges

   * 3% Origination Fee

   * 1% Guaranty Fee

5. Applications can be obtained from lender.



FEDERAL PARENT LOAN FOR UNDERGRADUATE STUDENTS (PLUS)

Cost of Education — Other Aid = Amount Parents can borrower

- ➤ (Variable Interest Rate - Max %)
- ➤ Origination Fee = 3%
- ➤ Guaranty Fee = 1%
- ➤ Repayment Terms = 10 Years

IX. Other PHEAA Educational Loan Programs

A. Health Education Assistance Loans (HEAL) 1-800-421-4817

1. For graduate health education students

2. Maximum eligibility

   * $12,500 per year;
   $50,000 aggregate
   Public Health
   Pharmacy
   Chiropractic
   Graduate Health Administration
   Clinical Psychology

   * $20,000 per year;
   $80,000 aggregate
   Medicine
   Osteopathy
   Dentistry
   Veterinary Medicine
   Podiatry

3. Variable interest rate; changes every three months.

4. Student must demonstrate financial need as determined by the school.

5. Applications and information are available in the school Financial Aid Office which serves the graduate health education students.

Other PHEAA Educational Loan Programs, (continued)

B. Law Access Loan 1-800-282-1550

1. Applications for the following types:

   a. Federal Stafford and Unsubsidized Stafford Loan
      * Reduced unsubsidized interest rate while in-school and in grace

   b. Private Law Access Loan (LAL)
      * Annual borrowing limit is up to the costs of attendance
      * Aggregate Maximum is $120,000.00
      * Variable interest rate charges quarterly - capitalized once at repayment
      * Reduced interest rate while in-school and in grace period

   c. Bar Examination Loan (BEL)
      * Up to $5,000.00 - disbursed one time in graduating year

2. Applications available in the Financial Aid Office at eligible participating ABA law schools or by calling the program administrator, The Access Group.

C. Business Access Loan 1-800-282-1550

1. Applications for the following loan types:

   a. Federal Stafford and Unsubsidized Stafford Loans
      * Reduced unsubsidized interest rate while in-school and in grace

   b. Private Business Access Loan (BAL)
      * If attending at least half-time, can borrow up to the cost of attendance
      * If less than half-time can borrow up to the combined cost of tuition, fees, and a maximum of $500.00 for books and supplies
      * Variable interest rate changes quarterly - capitalized once at repayment
      * Reduced interest rate prior to the commencement of repayment

2. Applications available through the Financial Aid Office at eligible participating AACSB business schools, or by calling the program administrator, The Access Group.

D. Dental Access Loan 1-800-282-1550

1. Applications for the following loan types:
    a. Federal Stafford and Unsubsidized Stafford Loans
        - Reduced unsubsidized interest rate while in-school and in grace

    b. Private Dental Access Loan (DAL)
        - If attending at least half-time, can borrow up to the cost of attendance
        - If less than half-time, can borrow up to the combined cost of tuition, fees, and a maximum of $500.00 for books and supplies
        - Variable interest rate changes quarterly - capitalized once at repayment
        - Reduced interest rate prior to the commencement of repayment

2. Applications available through the Financial Aid Office at eligible participating dental schools, or by calling the program administrator, The Access Group.

E. Medical Access Loan 1-800-282-1550

1. Applications for the following loan types:
    a. Federal Stafford and Unsubsidized Stafford Loans
        - Reduced unsubsidized interest rate while in-school and in grace

    b. Private Medical Access Loan (MAL)
        - If attending at least half-time, can borrow up to the cost of attendance
        - If less than half-time, can borrow up to the combined cost of tuition, fees, and a maximum of $500.00 for books and supplies
        - Variable interest rate changes quarterly - capitalized once at repayment
        - Reduced interest rate prior to the commencement of repayment

    c. Residency Loan
        - Loan to be used for interview and relocation expenses
        - Maximum of $8,000
        - Repayment begins 9 months after status drops to less than half-time or after the completion of a required residency medical program (not to exceed 48 months)

2. Applications available through the Financial Aid Office at eligible participating medical schools, or by calling the program administrator, The Access Group.

F. Graduate Access Loan 1-800-282-1550

1. Applications for the following loan types:

   a. Federal Staff and Unsubsidized Stafford Loans
      - Reduced unsubsidized interest rate while in-school and in grace

   b. Private Graduate Access Loan (GAL)
      - If attending at least half-time, can borrow up to the costs of attendance
      - If less than half-time, can borrower up to the combined cost of tuition, fees, and a maximum of $500.00 for books and supplies
      - Variable interest rate changes quarterly - capitalized once at repayment
      - Reduced interest rate prior to the commence of repayment

2. Applications available through the Financial Aid Office at eligible participating graduate schools, or by calling the program administrator, The Access Group.

X. School Services (717) 257-5220

1. PHEAA's Career Guidance Network, (PCGN)

   Combined Package Includes:

   a. Keys to Educational Opportunities

      * Software which provides information about postsecondary institutions, including admissions, financial aid, degrees, and general demographic information.

   b. PAIS - PHEAA Aid Information System

      * Software which permits a student to enter income and asset information, and receive an estimate of State Grant, Pell Grant, and subsidized Stafford Loan eligibility.

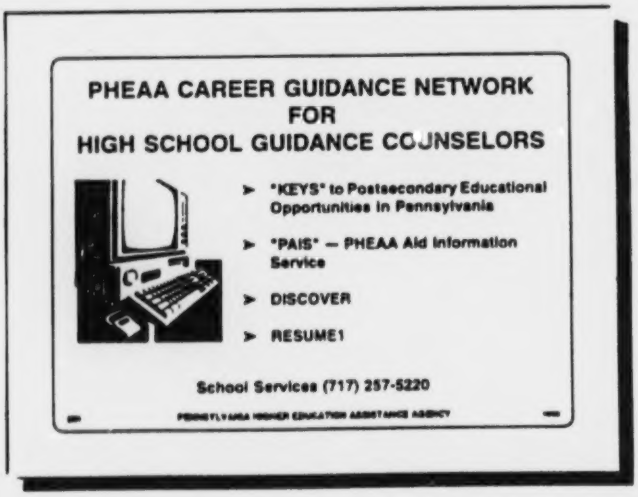
2. RESUME1

   * Resume development, cover, and thank you letters

3. Discover (an ACT Program)

   * Three versions: Junior High, High School, and College/Adult

   * Computerized career/school guidance programs targeted to each of these groups.



PHEAA CAREER GUIDANCE NETWORK
FOR
HIGH SCHOOL GUIDANCE COUNSELORS

- "KEYS" to Postsecondary Educational Opportunities in Pennsylvania
- "PAIS" — PHEAA Aid Information Service
- DISCOVER
- RESUME1

School Services (717) 257-5220

PENNSYLVANIA HIGHER EDUCATION ASSISTANCE AGENCY

XI. Other Programs

A. Urban and Rural Teacher Loan Forgiveness Program (717) 257-5220

1. PHEAA will pay up to $2,500 per year; maximum of $10,000 on PHEAA administered Stafford and SLS Loans.

2. For persons with a four year degree in their first full year teaching at time of application.

3. Must be employed on a full-time permanent basis teaching the major portion of the school day.

4. Must be certified to teach in Pennsylvania by Pennsylvania Department of Education.

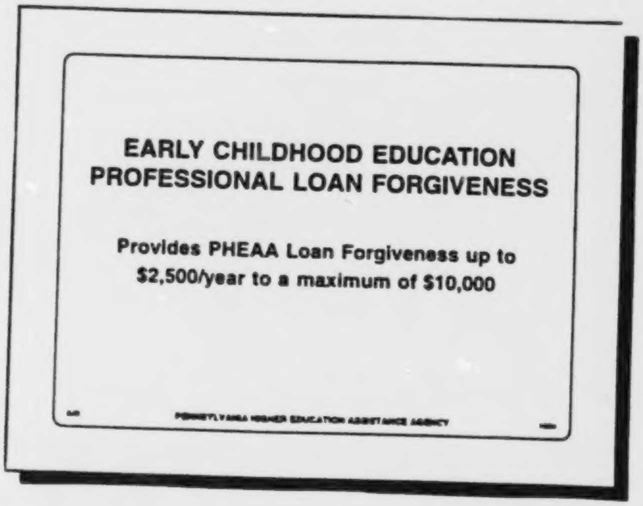
5. Must be teaching in a Commonwealth designed urban or rural public school district or at a non-profit non-public school in a district where students may fulfill compulsory attendance requirements.

6. Applications are available in the principal's or superintendent's office, or by contacting PHEAA.

Other Programs, (continued)

B. Early Childhood Education Professional Loan Forgiveness - Provides student loan forgiveness up to $2,500 a year to a maximum of $10,000. (717) 257-5220

1. Qualifications:
    a. Must have a Bachelor's Degree and PA Early Childhood Education Certification, or an Associate's Degree in Early Childhood Education Development.
    b. Must have borrowed student loans guaranteed by PHEAA.
    c. Should not be in default on student loans or delinquent on any payment due any Pennsylvania Agency.
    d. Should be a resident of Pennsylvania.
    e. Must receive a salary less than $18,500 a year as a full-time professional in a PA DPW approved child day care center or group day care home.
2. Applications are available at early child care centers or by contacting PHEAA.



EARLY CHILDHOOD EDUCATION PROFESSIONAL LOAN FORGIVENESS

Provides PHEAA Loan Forgiveness up to $2,500/year to a maximum of $10,000

Other Programs, continued

C. PHEAA Network Consolidation 1-800-338-5000

1. Borrower with Title IV (no minimum) indebtedness can combine the following loans at weighted average rate (no caps):

   - Stafford (subsidized and a non-subsidized)
   - Supplemental Loans to Students (SLS)
   - Health Professional Student Loans (HPSL)
   - Perkins Loans (formerly National Direct/Defense Student Loans)
   - Parent Loans for Undergraduate Students (PLUS)

   Note: A borrower with high indebtedness to one of these loan programs can take advantage of the Network Consolidation Program.

2. Payment arrangements for terms up to 30 years may be possible, based on the borrower's total indebtedness.

3. Borrower calls PHEAA Network Consolidation Loan staff at the toll-free number. Staff will counsel borrower, and send application and other information about the program.

4. This program should be used by borrowers after the completion of the educational program to manage high levels of indebtedness.

Program Highlights

It is important to remember when counseling students as to their choice of professions and schools, that a debt management tool, the NETWORK CONSOLIDATION PROGRAM, is offered to student loan borrowers upon completion of their postsecondary education. A NETWORK LOAN allows a student a smaller monthly payment HOWEVER a longer repayment term is incurred.

j:\common\krd\GCTom
10/95

UNITED STATES DEPARTMENT OF EDUCATION
WASHINGTON, D.C. 20202-________

Dear *FAFSA Express* User:

Thank you for ordering the U.S. Department of Education's ***1995-96 FAFSA Express*** software. ***FAFSA Express*** allows students to complete and transmit the Free Application for Federal Student Aid using a PC and modem. We are very excited about the software's ability to enhance the Federal student aid application process.

FAFSA Express will significantly shorten the application process. After the student enters the application, the information is edited by the software for logic and consistency. ***FAFSA Express*** highlights responses that are inconsistent or incomplete and prompts the student to change them. ***FAFSA Express*** then transmits the student's record to the Department of Education. If a printer is available, ***FAFSA Express*** prints a copy of the student's application data and a signature page. After the student (and parent, if necessary) signs and mails the signature page to the Department, the signature is appended to the student's electronic record, completing the application. Within two weeks the student will receive a Student Aid Report (SAR) in the mail with processing results.

If a printer is not available, ***FAFSA Express*** notes this on the student's record and transmits the application. The student will receive a SAR which he or she must sign and return to the Department to complete the application. The student will then receive a SAR with processing results.

Included in this packet are the ***FAFSA Express*** software (on 3-1/2" diskette) and User Guide, and envelopes necessary to send printed signature pages to the Department. Also included is a stand-up card designed to be placed on or near the PC where ***FAFSA Express*** resides. The stand-up card provides information the student needs before using ***FAFSA Express***.

This version of ***FAFSA Express*** uses the Department's current General Electronic Support (GES) network, and can be used through December 31, 1995 for the 1995-96 cycle. In late November there will be a version available using the Department's new Title IV WAN network. You will need to call and order this new version, and at the same time you can request the 1996-97 version which will be sent to you in January of 1996.

FAFSA Express is provided free-of-charge. The software is not copyrighted and may be installed on any number of PCs. ***FAFSA Express*** may also be copied and distributed to students who have PCs in their homes. Transmission of records is done at no cost to the sender. The ***FAFSA Express*** User Guide contains complete instructions on installing the software. You can also call the ***FAFSA Express*** Customer Service number, 1-800-801-0576, if you need assistance with hardware, software, or installation.

Sincerely,

Jeanne B Saunders

Jeanne B. Saunders
Director, Application and
Pell Processing Systems Division

Enclosures

DRAFT **SAMPLE** **DRAFT**

Free Application for Federal Student Aid

1996-97 School Year

WARNING: If you purposely give false or misleading information on this form, you may be fined $10,000, sent to prison, or both.

"You" and "your" on this form always mean the student who wants aid.

Form Approved
OMB No. 1840-0110
App. Exp. 6/30/97

U.S. Department of Education
Student Financial
Assistance Programs

Print in capital letters with a dark ink. B E R 2 4 *Fill in ovals completely.* Right ● Wrong

Section A: You (the student)

1–3. Your name — 1. Last name ☐ 2. First name ☐ 3. M.I. ☐

Your title (optional) — Mr. ○ 1 Miss, Mrs., or Ms. ○ 2

4–7. Your permanent mailing address *(All mail will be sent to this address. See Instructions, page 2 for state/country abbreviations.)*

4. Number and street (Include apt. no.) ☐

5. City ☐ 6. State ☐ 7. ZIP code ☐

8. Your social security number (SSN) *(Don't leave blank. See Instructions, page 2.)* ☐

9. Your date of birth — Month Day Year ☐

10. Your permanent home telephone number — Area code ☐

11. Your state of legal residence — State ☐

12. Date you became a legal resident of the state in question 11 *(See Instructions, page 2.)* — Month Day Year ☐

13–14. Your driver's license number *(Include the state abbreviation. If you don't have a license, write in "None.")*

State ☐ License number ☐

15–16. Are you a U.S. citizen? *(See Instructions, pages 2–3.)*

Yes, I am a U.S. citizen. ○ 1

No, but I am an eligible noncitizen. ○ 2 A ☐

No, neither of the above. ○ 3

17. As of today, are you married? *(Fill in only one oval.)*

I am not married. (I am single, widowed, or divorced.) ○ 1

I am married. ○ 2

I am separated from my spouse. ○ 3

18. Date you were married, separated, divorced, or widowed. If divorced, use date of divorce or separation, whichever is earlier. *(If never married, leave blank.)* — Month Year ☐

19. Will you have your first bachelor's degree before July 1, 1996? Yes ○ 1 No ○ 2

Section B: Education Background

20–21. Date that you (the student) received, or will receive, your high school diploma, either—

- by graduating from high school — Month Year ☐

OR

- by earning a GED — Month Year ☐

(Enter one date. Leave blank if the question does not apply to you.)

22–23. Highest educational level or grade level your father and your mother completed. *(Fill in one oval for each parent. See Instructions, page 3.)*

	22. Father	23. Mother
elementary school (K–8)	○ 1	○ 1
high school (9–12)	○ 2	○ 2
college or beyond	○ 3	○ 3
unknown	○ 4	○ 4

If you (and your family) have **unusual circumstances**, complete this form and then check with your financial aid administrator. Examples:

- tuition expenses at an elementary or secondary school,
- unusual medical or dental expenses not covered by insurance,
- a family member who recently became unemployed, or
- other unusual circumstances such as changes in income or assets that might affect your eligibility for student financial aid.

Section C: Your Plans *Answer these questions about your college plans.*

24–28. Your expected enrollment status for the 1996-97 school year *(See Instructions, page 3.)*

School term	Full time	3/4 time	1/2 time	Less than 1/2 time	Not enrolled
24. Summer term '96	○ 1	○ 2	○ 3	○ 4	○ 5
25. Fall semester/qtr. '96	○ 1	○ 2	○ 3	○ 4	○ 5
26. Winter quarter '96-97	○ 1	○ 2	○ 3	○ 4	○ 5
27. Spring semester/qtr. '97	○ 1	○ 2	○ 3	○ 4	○ 5
28. Summer term '97	○ 1	○ 2	○ 3	○ 4	○ 5

29. Your course of study *(See Instructions for code, page 3.)* Code ☐

30–31. College degree/certificate you expect to receive and the date you expect to receive it *(See Instructions for code, page 3.)*

30. Degree/certificate ☐

31. Date Month Day Year ☐

32. Your grade level during the 1996-97 school year *(Fill in only one.)*

1st yr./never attended college	○ 1	5th year/other undergraduate	○ 6
1st yr./attended college before	○ 2	1st year graduate/professional	○ 7
2nd year/sophomore	○ 3	2nd year graduate/professional	○ 8
3rd year/junior	○ 4	3rd year graduate/professional	○ 9
4th year/senior	○ 5	Beyond 3rd year graduate/professional	○ 0

33–35. In addition to grants, what other types of financial aid are you (and your parents) interested in? *(See Instructions, page 3.)*

33. Student employment Yes ○ 1 No ○ 2

34. Student loans Yes ○ 1 No ○ 2

35. Parent loans for students Yes ○ 1 No ○ 2

36. If you are (or were) in college, do you plan to attend **that same college** in 1996-97? *(If this doesn't apply to you, leave blank.)* Yes ○ 1 No ○ 2

37. For how many dependents will you pay child care or elder care expenses in 1996-97? ☐

38–39. Veterans education benefits you expect to receive from July 1, 1996 through June 30, 1997

38. Amount per month ☐

39. Number of months ☐

Section D: Student Status

yes to any of these denotes dependency

40. Were you born before January 1, 1973? .... Yes ○ 1 No ○ 2

41. Are you a veteran of the U.S. Armed Forces? .... Yes ○ 1 No ○ 2

42. Will you be enrolled in a graduate or professional program (beyond a bachelor's degree) in 1996-97? .... Yes ○ 1 No ○ 2

43. Are you married? .... Yes ○ 1 No ○ 2

44. Are you an orphan or a ward of the court, or were you a ward of the court until age 18? .... Yes ○ 1 No ○ 2

45. Do you have legal dependents (other than a spouse) that fit the definition in Instructions, page 4? .... Yes ○ 1 No ○ 2

If you answered "Yes" to any question in Section D, go to Section E and fill out the GRAY and the WHITE areas on the rest of this form.

If you answered "No" to every question in Section D, go to Section E and fill out the RED and the WHITE areas on the rest of this form.

Section E: Household Information

If you are filling out the GRAY and WHITE areas, answer questions 46 and 47 and go to Section F.

If you are filling out the RED and WHITE areas, skip questions 46 and 47. Answer questions 48 through 52 about your parents, and then go on to Section F.

STUDENT (& SPOUSE)

46. Number in your household in 1996-97 Include yourself and your spouse. Do not include your children and other people unless they meet the definition in Instructions, page 4. ☐

47. Number of college students in household in 1996-97 Of the number in 46, how many will be in college at least half-time in at least one term in an eligible program? Include yourself. *(See Instructions, page 4.)* ☐

PARENT(S)

48. Your parents' current marital status:

single ○ 1 separated ○ 3 widowed ○ 5

married ○ 2 divorced ○ 4

49. Your parent(s)' state of legal residence State ☐

50. Date your parent(s) became legal resident(s) of the state in question 49 *(See Instructions, page 5.)* Month Day Year ☐

51. Number in your parents' household in 1996-97 Include yourself and your parents. Do not include your parents' other children and other people unless they meet the definition in Instructions, page 5. ☐

52. Number of college students in household in 1996-97 Of the number in 51, how many will be in college at least half-time in at least one term in an eligible program? Include yourself. *(See Instructions, page 5.)* ☐

DRAFT SAMPLE DRAFT

Section F: 1995 Income, Earnings, and Benefits

Everyone must fill out the Student (& Spouse) column.

You must see Instructions, pages 5 and 6, for information about tax forms and tax filing status, especially if you are estimating taxes or filing electronically or by telephone. These instructions will tell you what income and benefits should be reported in this section.

The following 1995 U.S. income tax figures are from:	STUDENT (& SPOUSE) 53. *(Fill in only one.)*	PARENT(S) 65. *(Fill in only one.)*
A—a completed 1995 IRS Form 1040A, 1040EZ, or 1040TEL	○ 1	A ○ 1
B—a completed 1995 IRS Form 1040	○ 2	B ○ 2
C—an estimated 1995 IRS Form 1040A, 1040EZ,or 1040TEL	○ 3	C ○ 3
D—an estimated 1995 IRS Form 1040	○ 4	D ○ 4
E—will not file a 1995 U.S. income tax return	*(Skip to question 57.)* ○ 5	E *(Skip to 69.)* ○ 5

TAX FILERS ONLY

1995 Total number of exemptions (Form 1040–line 6e, or 1040A–line 6e; 1040EZ filers— *see Instructions, page 6.*)	54. ☐	66. ☐
1995 Adjusted Gross Income (AGI: Form 1040–line 31, 1040A–line 16, or 1040EZ–line 4—*see Instructions, page 6.*)	55. $ .00	67. $ .00
1995 U.S. income tax **paid** (Form 1040–line 46, 1040A–line 25, or 1040EZ–line 10	56. $ .00	68. $ .00
1995 Income earned from work	(Student) 57. $ .00	(Father) 69. $ .00
1995 Income earned from work	(Spouse) 58. $ .00	(Mother) 70. $ .00

1995 Untaxed income and benefits (yearly totals only):

Earned Income Credit (Form 1040–line 57; Form 1040A–line 29c; Form 1040EZ–line 8)	59. $ .00	71. $ .00
Social Security Benefits	60. $ .00	72. $ .00
Aid to Families with Dependent Children (AFDC/ADC)	61. $ .00	73. $ .00
Child support received for all children	62. $ .00	74. $ .00
Other untaxed income and benefits from Worksheet #2, page 11	63. $ .00	75. $ .00
1995 Total from Worksheet #3, page 12	64. $ .00	76. $ .00

ATTENTION

Section G: Asset Information

Fill out Worksheet A or Worksheet B in Instructions, page 7.

If you meet the tax filing and income conditions on Worksheets A and B, you do not have to complete Section G to apply for Federal student aid. Some states and colleges, however, require Section G information for their own aid programs. Check with your financial aid administrator.

Age of your older parent 84. ☐

	STUDENT (& SPOUSE)	PARENT(S)
Cash, savings, and checking accounts	77. $ .00	85. $ .00
Other real estate and investments value *(Don't include the home.)*	78. $ .00	86. $ .00
Other real estate and investments debt *(Don't include the home.)*	79. $ .00	87. $ .00
Business value	80. $ .00	88. $ .00
Business debt	81. $ .00	89. $ .00
Investment farm value *(See Instructions, page 8.)*	82. $ .00	90. $ .00
Investment farm debt *(See Instructions, page 8.)*	83. $ .00	91. $ .00

DRAFT **SAMPLE** **DRAFT**

Section H: Releases and Signatures

92–103. What college(s) do you plan to attend in 1996–97? *(Note: The colleges you list below will have access to your application information. See Instructions, page 8.)*

Housing codes 1—on-campus 2—off-campus 3—with parent(s) 4—with relative(s) other than parent(s)

	Title IV Code	College Name	College Street Address and City	State		Housing Code
XX.	0 5 4 3 2 1	*Example University*	*14930 North Somewhere Boulevard* *Anywhere City*	S T	XX.	2
92.					93.	
94.					95.	
96.					97.	
98.					99.	
100.					101.	
102.					103.	

104. The U.S. Department of Education will send information from this form to your state financial aid agency and the state agencies of the colleges listed above so they can consider you for state aid. Answer "No" if you don't want information released to the state. *(See "Deadlines for State Student Aid" in Instructions, page 10.)* .... **104. No** ○ 2

105. Males not yet registered for Selective Service: Do you want us to register you? *(See Instructions, page 9.)* .... **105. Yes** ○ 1

106–107. Read, Sign, and Date

All of the information provided by me or any other person on this form is true and complete to the best of my knowledge. I understand that this application is being filed jointly by all signatories. If asked by an authorized official, I agree to give proof of the information that I have given on this form. I realize that this proof may include a copy of my U.S. or state income tax return. I also realize that if I do not give proof when asked, the student may be denied aid.

Certification Statement on Overpayments and Defaults. I understand that I may not receive any Federal Title IV, HEA funds if I owe an overpayment on any Title IV educational grant or am in default on a Title IV educational loan unless I have made satisfactory arrangements to repay or otherwise resolve the overpayment or default. I also understand that I must notify my school if I do owe an overpayment or am in default.

Statement of Educational Purpose. I certify that I will use any Federal Title IV, HEA funds I receive during the award year covered by this application solely for expenses related to my attendance at the institution of higher education that determined or certified my eligibility for those funds.

Everyone whose information is given on this form should sign below. The student (and at least one parent, if parental information is given), must sign below or this form will be returned unprocessed.

106. Signatures

1 Student

2 Student's Spouse

3 Father/Stepfather

4 Mother/Stepmother

107. Date completed

Month Day

Year 1996 ○ 1997 ○

School Use Only D/O ○

Title IV Code

FAA Signature

1

MDE Use Only *Do not write in this box* Spec. handle ☐ No. copies ☐

Section I: Preparer's Use Only

For preparers other than student, spouse, and parent(s). Student, spouse, and parent(s), sign above.

Preparer's name (last, first, MI)

Firm name

Firm or preparer's address (street, city, state, ZIP)

108. Employer identification number (EIN)

OR

109. Preparer's social security number

Certification: All of the information on this form is true and complete to the best of my knowledge.

110. Preparer's signature **Date**

1

MAKE SURE THAT YOU HAVE COMPLETED, DATED, AND SIGNED THIS APPLICATION.
Mail the application to: Federal Student Aid Programs, P.O. Box —, XXXXXXX

DRAFT **SAMPLE** **DRAFT**

Free Application for Federal Student Aid

1996-97 School Year

Form Approved
OMB No. 1840-0110
App. Exp. 6/30/97

U.S. Department of Education
Student Financial Assistance Programs

If you were in college last year and meet certain conditions, you will receive a renewal application in the mail or from your school early in 1996. You must use either the **Renewal FAFSA or this Free Application for Federal Student Aid (FAFSA)** to apply for aid from Federal student financial aid programs.

You can also use the Renewal FAFSA or this FAFSA to apply for most state and some private aid, although certain state and private aid programs may require an additional form. To find out more about which forms to use, contact your high school counselor, college financial aid office, or state scholarship/ grant agency.

Be sure to read INFORMATION ON THE PRIVACY ACT AND USE OF YOUR SOCIAL SECURITY NUMBER on page 12.

WARNING: You must fill out this form accurately. The information that you supply can be verified by your college, your state, or by the U.S. Department of Education.

You may be asked to provide U.S. income tax returns, the worksheets in this booklet, and other information. If you can't or don't provide these records to your college, you may not get Federal student aid. If you get Federal student aid based on incorrect information, you will have to pay it back; you may also have to pay fines and fees. If you purposely give false or misleading information on your application, you may be fined $10,000, sent to prison, or both.

WHAT IS THIS APPLICATION FOR?

Federal Student Financial Aid

"Federal student financial aid" means Federal grant, loan and work-study money for your education.

The Federal student assistance programs can help you pay for most kinds of education after high school. The aid is available if you are attending a college, a professional school, or a vocational or technical school. This application is for Federal student financial aid for the 1996-97 school year (July 1, 1996–June 30, 1997).

STATE AND COLLEGE STUDENT FINANCIAL AID

Some state and college aid programs may require additional information. Contact your state scholarship/grant agency or college financial aid administrator to find out whether you need to complete any form(s) in addition to the FAFSA, and what types of aid you might be eligible for. Be sure to see the **deadline dates** under "Deadlines for State Student Aid" on page 10. Some colleges also have their own deadlines, which may be earlier than the Federal deadline.

For more information on applying for student aid, see WHAT HAPPENS NEXT? on page 10.

This application is used for these Federal Student Financial Aid Programs

Federal Pell Grants
Federal Supplemental Educational Opportunity Grants (FSEOG)
Federal Subsidized and Unsubsidized Stafford Loans
Stafford/Ford Federal Direct Subsidized and Unsubsidized Loans
Federal Perkins Loans
Federal Work-Study (FWS)
Title VII and Public Health Act Programs

To be eligible, you must . . .

- be a U.S. citizen or eligible noncitizen,
- be registered with Selective Service (if required),
- attend a participating college,
- be working toward a degree or certificate,
- be making satisfactory academic progress,
- not owe a refund on a Federal grant or be in default on a Federal educational loan, and
- have financial need (except for Unsubsidized Stafford Loans).

In addition:

- Federal student loans must be repaid.
- Less-than-half-time students may be eligible for Federal Pell Grants and some other Federal student aid programs.
- Students who have received a bachelor's degree are not eligible for Federal Pell Grants or FSEOG, but may be eligible for other Federal student aid programs.
- Students attending two schools in the same enrollment period must inform both FAAs. Students can not receive Pell Grants at both schools.
- Conviction of drug distribution or possession may make a student ineligible.

DEADLINES

FEDERAL STUDENT AID—JANUARY 1, 1996 TO JUNE 30, 1997
You should apply as early as possible **but not before January 1, 1996.** Mailing in your form is only the first step in applying for student aid. **We must receive your form no later than June 30, 1997.**

FOR STATE STUDENT AID—SEE PAGE 10
State deadlines may be earlier than the Federal deadline. Your state may also require an additional form. Check the requirements and deadlines.

FOR COLLEGE AID—CHECK WITH YOUR FINANCIAL AID OFFICE. Colleges may have their own deadlines and applications for awarding student aid.

If you (and your family) have unusual circumstances, such as tuition expenses at an elementary or secondary school, unusual medical or dental expenses not covered by insurance, a family member who recently became unemployed, or changes in income or assets that affect your eligibility for financial aid, complete this form and then check with your college financial aid office.

DRAFT SAMPLE DRAFT

INSTRUCTIONS

FOR RED SHADED AREAS

FOR GRAY SHADED AREAS

Before you begin to fill out this form, TEAR IT OUT and lay it alongside the instruction book so that you can check for additional instructions as you go along.

The **RED** and **GRAY** areas indicate which instructions are for which questions. **Read the instructions as you fill out this form.** Mistakes will delay the processing of your application.

Some questions on the form are self-explanatory, and no additional instructions are provided. These are questions 9, 10, and 17.

Although other people (besides the student who is applying for aid) may help fill out this form, it is about the student. On this form, the words "you" and "your" always mean the student. The word "college" means a college, university, graduate or professional school, community college, vocational or technical school, or any other school beyond high school.

If you need more help, ask your high school guidance counselor or your college financial aid administrator to explain the instructions to you.

Records You Will Need
Keep these records! You may need them again.

- Student's driver's license and social security card
- W-2 Forms and other records of money earned in 1995
- 1995 U.S. income tax return (IRS Form 1040, 1040A, or 1040EZ) If you haven't completed your tax return, see page 5.
- Records of untaxed income, such as welfare, social security, AFDC or ADC, or veterans benefits
- Current bank statements
- Current mortgage information
- Business and farm records
- Records of stocks, bonds, and other investments

Special Instructions. If you (your spouse or parents) file a Puerto Rico or foreign tax return, see page 9. If you are a Native American or a citizen of the Federated States of Micronesia, the Marshall Islands, or Palau, see the special instructions on page 9.

When You Fill Out This Form

- **You must use a pen with black or dark ink, or a #2 pencil.**
- **Print carefully, do not write "N/A" or margin notes on the form!**
- **Fill in ovals completely, like this: ●**
- **For errors, use white-out or erase completely.**
- Round off all figures to the nearest dollar. For 50 cents or more, round up; for 49 cents or less, round down.
- For dates, write in numbers that correspond to the month, day, and year. For example, for November 7, 1974, write in 11-07-74.
- Questions about your plans and references to the "school year" mean the school year from July 1, 1996 through June 30, 1997.
- If you are applying to more than one college, answer the questions about enrollment according to your plans for your first-choice college.

Section A: You (the student)

1–3. Use your proper name, not a nickname. Your social security number (SSN) and your name should match the number and name on your social security card. If there are differences, you should update your information with the Social Security Administration.

4–7. Write in your permanent mailing address. All mail will be sent to this address. Don't use the address of the financial aid office or any other office. Use the state/country abbreviations list below.

State/Country Abbreviations

AL	Alabama
AK	Alaska
AS	American Samoa
AZ	Arizona
AR	Arkansas
CA	California
CO	Colorado
CT	Connecticut
DE	Delaware
DC	District of Columbia
FL	Florida
GA	Georgia
GU	Guam
HI	Hawaii
ID	Idaho
IL	Illinois
IN	Indiana
IA	Iowa
KS	Kansas
KY	Kentucky
LA	Louisiana
ME	Maine
MD	Maryland
MA	Massachusetts
MI	Michigan
MN	Minnesota
MS	Mississippi
MO	Missouri
MT	Montana
NE	Nebraska
NV	Nevada
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NY	New York
NC	North Carolina
ND	North Dakota
OH	Ohio
OK	Oklahoma
OR	Oregon
PA	Pennsylvania
PR	Puerto Rico
RI	Rhode Island
SC	South Carolina
SD	South Dakota
TN	Tennessee
TX	Texas
UT	Utah
VT	Vermont
VI	Virgin Islands
VA	Virginia
WA	Washington
WV	West Virginia
WI	Wisconsin
WY	Wyoming
Military	
AA	
AE	
AP	
CN	Canada
FM	Federated States of Micronesia
MH	Marshall Islands
MX	Mexico
MP	Northern Mariana Islands
PW	Palau

If your place of residence is not on the list above, leave the state abbreviation blank and write the name of your city and territory or country in the space for city.

8. You must write in your social security number (SSN) to be considered for Federal student aid. If you don't write your SSN, this form will be returned unprocessed. The Privacy Act statement on page 12 gives information about your protections and how your social security number can be used.

11. Write in the two-letter abbreviation for your current state/country of legal residence. Use the state/country abbreviations list above. Residency (domicile) is your true, fixed, and permanent home. If you moved into a state for the sole purpose of attending a college, **don't** count that state as your legal residence.

12. Write in the date you became a legal resident of the state you listed in question 11. If you've always lived in the state, you may use your date of birth as the date of legal residence. If you don't know the exact day that you became a legal resident, provide the month and year.

13–14. Write in your driver's license number, starting with the abbreviation of the state in which the license was issued (use the state/country abbreviation list above). If you have a driver's license, you must provide the license number if you previously received, or plan to apply for, a Federal student loan. If you don't have a driver's license, write "None" in the space for license number.

15–16. If you are a U.S. citizen (or U.S. national), fill in the first oval and go on to question 17. Fill in the second oval and write in your eight- or nine-digit Alien Registration Number if you are one of the following:

- U.S. permanent resident, and you have an Alien Registration Receipt Card (I-151 or I-551).
- Other eligible noncitizen with an Arrival-Departure Record (I-94) from the U.S. Immigration and Naturalization Service showing any one of the following designations: (a) "Refugee," (b) "Asylum Granted," (c) "Indefinite Parole" and/or "Humanitarian Parole," (d) "Cuban-Haitian Entrant."
- Other eligible noncitizen with a Temporary Resident Card (I-688).

If you cannot fill in the first or second oval, you must fill in the third oval. If you are in the U.S. on only an F1 or F2 student visa, only a J1 or J2 exchange visitor visa, or only a G series visa (pertaining to international organizations), you must fill in the third oval. **You may be eligible for some state or college aid.**

18. If you, the student, are currently married, separated, or widowed, write in the date you married, became separated, or were widowed. If you were never married, leave this question blank.

If your current marital status is "divorced," write in the date you separated or were divorced, whichever was earlier.

19. Answer **"No"** if you do not have a bachelor's degree from a college and you will not have one by July 1, 1996. Answer **"Yes"** if you already have a bachelor's degree or will have one by July 1, 1996. Also answer **"Yes"** if you have or will have a degree from a college in another country that is equal to a bachelor's degree.

Section B: Education Background

20–21. Write in one date: either the date that you graduated or expect to graduate from high school, or the date that you earned or expect to earn a certificate or diploma through the General Education Development (GED) program.

Leave both dates blank if you will not graduate from high school and will not receive a GED certificate.

Pennsylvania residents only. Leave both dates blank if you received a military GED, a foreign high school diploma, a home study diploma, or a correspondence school diploma.

22–23. These questions are for state scholarship purposes only and do not affect your eligibility for Federal student aid. For these questions only, "father" and "mother" mean your birth parents, or your adoptive parents, or legal guardian—not your foster parents or stepparents. Fill in one oval for your father's highest educational level or grade level completed, and one oval for your mother's highest educational level or grade level completed.

Section C: Your Plans

24–28. Fill in your expected enrollment status for the 1996-97 school year. If you are applying to more than one college, fill in the enrollment status and school terms that apply to the college you are most likely to attend. (See question 92.)

If you will be attending a nonterm or clock-hour institution, fill in your enrollment status and the term or terms that most closely match the time you will be enrolled.

29. Write in the two-digit number for your expected course of study, using the "Course of Study Code List" on this page. For example, if your course of study is bookkeeping, write in "04" for business management and administrative services. If your course of study is vocational/technical, such as mechanical or electrical repair, write in "25." If your course of study is not listed or you are undecided, write in "27."

Course of Study Code List

01	Agriculture
02	Architecture
03	Biological sciences (biology, zoology, etc.)
04	Business management and administrative services (mktg., mgmt., bkkp., acct., etc.)
05	Communications (journalism, advertising, etc.)
06	Computer sciences
07	Education
08	Engineering
09	English language/literature
10	Fine and performing arts
11	Foreign languages/literatures
12	Health profession (except nursing)
13	Home economics
14	Law
15	Liberal arts
16	Library sciences
17	Mathematics (includes statistics)
18	Nursing
19	Personal and miscellaneous services (cosmetology, culinary arts, massage, etc.)
20	Philosophy
21	Physical sciences (chemistry, physics, geology, etc.)
22	Social sciences and history (includes economics, geography, political science)
23	Psychology
24	Theological studies and religious vocations
25	Vocational/technical (construction, mechanical, transportation, etc.)
26	Wildlife, forestry, or marine sciences
27	Other/undecided

30–31. Write in the one-digit code for your expected degree or certificate, using the "Degree/Certificate Code List" below. If your degree or certificate does not fit any of these categories, or if you are undecided, enter "8." Then write the date that you expect to receive your degree or certificate. If your expected completion date will be the year 2000 or later, write the last two digits only, for example, write "00" for 2000, or "04" for 2004.

Degree/Certificate Code List

1	Certificate or diploma for completing an occupational, technical, or educational program (less than two-year program)
2	Certificate or diploma for completing an occupational, technical, or educational program (at least two-year program)
3	Associate degree (at least two-year degree)
4	1st bachelor's degree
5	2nd bachelor's degree
6	Teaching credential program (non-degree program)
7	Graduate or professional degree
8	Other/undecided

32. Fill in your grade level in college from July 1, 1996 through June 30, 1997. If you are currently a senior in high school or will be a first-time entering freshman, fill in "1st year/never attended college." "Grade level" does not mean the number of years you have attended college, but your grade level in regard to completing your degree/certificate. A student who is not enrolled full-time will require more years to reach the same grade level as a full-time student.

33–35. Answer **"Yes"** or **"No"** to indicate whether you are interested in student employment (for example, work-study programs) or a student loan. **Your parents,** not you, the student, would apply for the PLUS loan if they are interested in applying for a parent loan. Answering **"Yes"** does not obligate you or your parents to accept a loan or other student aid, nor does it guarantee that you will receive aid.

36. Answer "Yes" if you are (or were) in college and you plan to attend that same college in 1996-97. By "that same college" we mean the college you are attending now or the most recent college you have attended. If you are still in high school and are (or were) enrolled in college, leave this question blank. Also, leave this question blank if you have never previously attended college.

37. Report the number of people in your household for whom you, the student, will pay dependent care expenses while you are in college, for example, day-care or baby-sitting expenses.

38. Write in the amount of veterans education benefits you, the student, expect to receive per month from July 1, 1996 through June 30, 1997. The benefits you should write in include, but are not limited to, these programs: Selective Reserve Pay (Montgomery GI Bill–Chapter 106), New GI Bill (Montgomery GI Bill–Chapter 30), Post-Vietnam Veterans Educational Assistance Program [VEAP] (Chapter 32), Vocational Rehabilitation (Chapter 31), REPS (Restored Entitlement Benefits for Survivors–Section 156), Educational Assistance Program (Chapter 107), and Dependents Educational Assistance Program (Chapter 35).

Don't include Death Pension or Dependency & Indemnity Compensation (DIC).

39. Write in the number of months from July 1, 1996 through June 30, 1997 that you expect to receive veterans education benefits.

Section D: Student Status

Answer each of the questions numbered 40 through 45 with either "Yes" or "No." A blank counts as "No."

40. Fill in the correct oval. (See your answer to question 9.)

41. Answer "Yes" if you:
- have engaged in active service in the U.S. Army, Navy, Air Force, Marines, or Coast Guard; or were a cadet or midshipman at one of the service academies; and were released under a condition other than dishonorable; or
- are **not** a veteran **now** but will be one by June 30, 1997.

Answer "No" if you:
- never served in the U.S. Armed Forces,
- are only an ROTC student,
- are currently a cadet or midshipman at a service academy,
- are only a National Guard or Reserves enlistee and were not activated for duty, **or**
- are currently serving in the U.S. Armed Forces and will continue to serve through June 30, 1997.

42. Answer "Yes" if you will be enrolled in a graduate or professional program (a course of study beyond a bachelor's degree) in the first term of 1996-97. If your graduate status will change during the school year, see your financial aid administrator.

43. Answer "Yes" if you are legally married **as of today**. Also, answer "Yes" if you are separated. "Married" does not mean living together unless your state recognizes your relationship as a common law marriage.

44. Answer "Yes" if (1) you are currently a ward of the court or were a ward of the court until age 18, or (2) both your parents are dead **and** you don't have an adoptive parent or legal guardian. For a definition of "legal guardian," see page 9.

45. Answer "Yes" if you have any children who get more than half of their support from you. Also answer "Yes" if other people (not your spouse) live with you and get more than half of their support from you and will continue to get that support during the 1996-97 school year.

Important Instructions for Sections E, F, and H

The question numbers on this form correspond with the information that will be printed on your Student Aid Report (SAR).

If you answered "Yes" to any of the questions in Section D, you (and your spouse if you are married) must fill out both the WHITE areas and the GRAY areas. Questions that you, the student (and your spouse), must complete are numbered 1–47, 53–64, and 92–110; in some cases, you must also complete questions 77–83 about your (and your spouse's) assets.

If you answered "No" to every one of the questions in Section D, then you must fill out the WHITE areas (about yourself) and the RED areas about your parents. Questions that you and your parents must complete are numbered 1–45, 48–76, and 92–110; in some cases you must also complete questions 77–91 about your and your parents' assets.

ATTENTION: GRADUATE HEALTH PROFESSION STUDENTS
If you are applying for Federal student aid from graduate programs authorized under Title VII of the Public Health Service Act, you must give information about your parents, even if you answered "Yes" to one of the questions in Section D. If you are unsure about the requirements, check with the financial aid administrator at the college you plan to attend. If your college requires parental information, complete the RED, GRAY, and WHITE areas and make sure that at least one parent signs this form.

Section E: Household Information

Student (& Spouse) Household Information - GRAY Area

Fill out this section with information about yourself (and your spouse). If you are divorced, separated, or widowed, don't include information about your spouse.

46. Write in the number of people in your household that you will *support* between July 1, 1996 and June 30, 1997. Include yourself and your spouse. Include your children if they get more than half their *support* from you. Include other people only if they meet the following criteria: 1) they now live with you, **and** 2) they now get more than half their *support* from you **and** they will continue to get this support between July 1, 1996 and June 30, 1997. *(Support includes money, gifts, loans, housing, food, clothes, car, medical and dental care, payment of college costs, etc.)*

47. Write in the number of people from question 46, including yourself, who will be college students between July 1, 1996 and June 30, 1997. Always include yourself, even if you will be enrolled for less than half-time. Your spouse and other family members may be counted as college students only if they are enrolling (or are accepted for enrollment) for at least 6 credit hours in at least one term, or at least 12 clock hours per week. To be counted here, a college student must be working towards a degree or certificate leading to a recognized education credential at a college that is eligible to participate in any of the Federal student aid programs.

Parent(s) Household Information - RED Areas

Read the descriptions that follow. Fill in all the ovals that apply to you and follow the instructions.

○ **Your parents are both living and married to each other.** Answer the questions on the rest of this form about them.

○ **You have a legal guardian.** Answer the questions on the rest of this form about your legal guardian. For a definition of "legal guardian" see page 9.

○ **Your parents have divorced or separated.** Answer the questions on the rest of the form about the parent you lived with most in the last 12 months. If you did not live with one parent more than with the other, answer in terms of the parent who provided the most *financial* support during the last 12 months, or during the most recent calendar year that you actually were supported by a parent. *(Support includes money, gifts, loans, housing, food, clothes, car, medical and dental care, payment of college costs, etc.)*

○ **Your parent is widowed or single.** Answer the questions on the rest of this form about that parent.

○ **You have a stepparent.** If the parent that you counted above is married or remarried **as of today**, you must include information about your stepparent (even if they were not married in 1995).

If you are giving information about your stepparent, note that whenever we say "parents" on the rest of this form, we also mean your stepparent.

48. Show the current marital status of the people that you give information about on this form. For example, if you give information about your mother and stepfather, fill in the oval that says "married," because your mother and stepfather are married.

49. Write in the two-letter abbreviation for your parent(s)' current state/country of legal residence. See the list of abbreviations on page 2. Residency (domicile) is your parents' true, fixed, and permanent home. If your parents are residing in a state for the sole purpose of attending a college, don't count that state as their legal residence. If your parents are separated or divorced, use the state/country of legal residence for the parent whose information is reported on this form.

50. Write in the date your parent(s) became a legal resident(s) of the state you listed in question 49. If your parents became legal residents of the state at different times, use the date for the parent who has been a resident the longest. If your parents are divorced or separated, use the date for the parent whose information is reported on this form.

51. Write in the number of people in your household that your parents will *support* between July 1, 1996 and June 30, 1997. Include your parents and yourself. Include your parents' other children if they get more than half their *support* from your parents, or if they would be required to provide parental information when applying for Title IV Federal student aid in 1996-97. Include other people only if they now live with and get more than half their *support* from your parents and will continue to get this support between July 1, 1996 and June 30, 1997. *(Support includes money, gifts, loans, housing, food, clothes, car, medical and dental care, payment of college costs, etc.)*

52. Write in the number of people from question 51 who will be college students between July 1, 1996 and June 30, 1997. Always count yourself, even if you will be enrolled for less than half-time. Your parents and other family members may be counted as college students only if they are enrolling (or are accepted for enrollment) for at least 6 credit hours in at least one term, or at least 12 clock hours per week. To be counted here, a college student must be working towards a degree or certificate leading to a recognized education credential at a college that is eligible to participate in any of the Federal student aid programs.

Section F: 1995 Income, Earnings, and Benefits

Tax filing information for Section F

Won't file a tax return. Even if you, your spouse, and/or your parents don't file an income tax return for 1995, you will need to know earnings for the year. Use your W-2 Forms and other records to answer the questions here.

Tax return not completed - how estimated taxes are handled. We recommend that you complete your income tax return before filling out this application. However, it may be necessary to estimate tax information to meet state and college deadlines. When your application is compared with the official 1995 IRS Form 1040, 1040A, or 1040EZ that you and your family file, the financial information must agree. If there are differences, you will need to correct the information and send it back to the U.S. Department of Education. This could mean a delay in getting your student financial aid.

IRS Form 1040 filers. In certain instances, you, your spouse, or your parents may have filed a 1995 IRS Form 1040, even though you were **not required** to file a Form 1040. Tax preparers often file a Form 1040 or an electronic 1040 on behalf of the tax filer, even though that person's income and tax filing circumstances would allow him or her to file a 1040A or 1040EZ. If you are sure that you, your spouse, or your parents are not required to file a Form 1040, then fill in either oval "A" or oval "C" in question 53 and/or question 65 to indicate eligibility to file a 1040A or 1040EZ.

IRS 1040TEL filers. If you filed or will file a 1040TEL (tax filing by telephone, available in some states), fill in the oval for either the completed or estimated 1995 IRS Form 1040EZ in questions 53 and/or 65.

Puerto Rico Tax Filers, Foreign Tax Return Filers, and Native Americans, see page 9.

In Section F, if the instructions tell you to skip a question, leave it blank. If your answer to a question is "none" or "zero," put a zero in the answer space. Don't leave it blank or use dashes. For example:

$ 0 .00

Student (& Spouse) 1995 Income, Earnings, and Benefits

53. 1995 U.S. income tax form. Fill in only one oval to indicate which IRS form was filed or will be filed for 1995.

If you are currently divorced, separated, or widowed, but you filed (or will file) a joint tax return for 1995, give only your portion of the exemptions, income, and taxes paid asked for in questions 54 through 64.

If you are married and you and your spouse filed (or will file) separate tax returns for 1995, be sure to include both your and your spouse's exemptions and income in questions 54 through 64, even if you were not married in 1995.

Use the tax return to fill out questions 54 through 63.

54. Total number of exemptions for 1995. Write in the number from Form 1040-line 6e or 1040A-line 6e. If you (and your spouse) used the 1040EZ and answered **"Yes"** on Form 1040EZ-line 5, use the 1040EZ worksheet (line F) to determine the number of exemptions ($2500 equals 1 exemption). If you answered "No," enter "01" if you are single or "02" if you are married.

55. Adjusted Gross Income (AGI) for 1995. Write in the amount from IRS Form 1040-line 31, Form 1040A-line 16, or Form 1040EZ-line 4.

Use Worksheet #1 on page 11 to answer question 55 if you don't have a 1995 tax form but will be filing one.

56. U.S. Income tax paid for 1995. Write in the amount from IRS Form 1040-line 46, Form 1040A-line 25, or Form 1040EZ-line 10. Make sure this amount doesn't include any FICA, self-employment, or Other Taxes from Form 1040. **Don't** copy the amount of "Federal income tax withheld" from a W-2 Form.

57–58. Income earned from work in 1995.

If you filed or will file a tax return, include the "wages, salaries, tips, etc." from your (and your spouse's) Form 1040-line 7, 1040A-line 7, or 1040EZ-line 1. If you (and your spouse) filed a joint return, report your and your spouse's earnings separately. If you (and your spouse) own a business or farm, also add in the numbers from Form 1040-lines 12 and 18.

If you are not a tax filer, include your (and your spouse's) earnings from work in 1995. Add up the earnings from your (and your spouse's) W-2 Forms and any other earnings from work that are not included on the W-2 Forms.

59–63. Untaxed income and benefits for 1995. Don't include benefits reported in questions 71 through 75 of the Parent(s) column.

59. Earned Income Credit. Report the total amount of your (and your spouse's) Earned Income Credit from Form 1040–line 57, Form 1040A–line 29c, or Form 1040EZ–line 8.

60. Social security benefits for 1995. Write in the amount of untaxed social security benefits (including Supplemental Security Income) that you (and your spouse) got in 1995. Don't include any benefits reported in question 55. Don't report monthly amounts; write in the total for 1995. Be sure to include the amounts that you got for your children. Don't include amounts your parents received for you, which should be reported in questions 72 through 75.

61. Aid to Families with Dependent Children (AFDC or ADC) for 1995. Don't report monthly amounts; write in the total for 1995. Don't report social security benefits here.

62. Child support received for all children. Don't report monthly amounts; write in the total received for 1995.

63. Other untaxed income and benefits for 1995. Use Worksheet #2 on page 11. Add up your (and your spouse's) other untaxed income and benefits for 1995. Be sure to include your (and your spouse's) deductible IRA/Keogh payments, if any.

64. 1995 Total from Worksheet #3. Enter the total amount from Worksheet #3 on page 12. Write in "0" if the worksheet items don't apply to you (and your spouse).

Parent(s) 1995 Income, Earnings, and Benefits

65. 1995 U.S. income tax form. Fill in only one oval to indicate which IRS form was filed or will be filed for 1995.

If you are giving information for only one parent and that parent filed (or will file) a joint tax return for 1995, give only that parent's portion of the exemptions, income, and taxes paid asked for in questions 66 through 75.

If your parents are married and they filed (or will file) separate tax returns for 1995, be sure to include both parents' exemptions and income in questions 66 through 75.

Use the tax return to fill out questions 66 through 75.

66. Total number of exemptions for 1995. Write in the number from Form 1040-line 6e or 1040A-line 6e. If your parent(s) used the 1040EZ and answered **"Yes"** on Form 1040EZ-line 5, use the 1040EZ worksheet (line F) to determine the number of exemptions ($2500 equals 1 exemption). If your parent(s) answered **"No,"** enter "01" if your parent is single or "02" if your parents are married.

67. Adjusted Gross Income (AGI) for 1995. Write in the amount from IRS Form 1040-line 31, Form 1040A-line 16, or Form 1040EZ-line 4.

Use Worksheet #1 on page 11 to answer question 66 if your parents don't have a 1995 tax form but will be filing one.

68. U.S. income tax paid for 1995. Write in the amount from IRS Form 1040-line 46, Form 1040A-line 25, or Form 1040EZ-line 10. Make sure this amount doesn't include any FICA, self-employment, or Other Taxes from Form 1040. Don't copy the amount of "Federal income tax withheld" from a W-2 Form.

69–70. Income earned from work in 1995.

If your parent(s) filed or will file a tax return, include the "wages, salaries, tips, etc." from your parents' Form 1040-line 7, 1040A-line 7, or 1040EZ-line 1. If your parents filed a joint return, report your father's and mother's earnings separately. If your parents own a business or farm, also add in the numbers from Form 1040-lines 12 and 18.

If your parent(s) are not tax filers, write in your parents' earnings from work in 1995. Add up the earnings from your parents' W-2 Forms and any other earnings from work that are not included on the W-2 Forms.

[illegible]-75. Untaxed income and benefits for 1995.

71. Earned Income Credit. Report the total amount of your parents' Earned Income Credit from Form 1040–line 57, Form 1040A–line 29c, or Form 1040EZ–line 8.

72. Social security benefits for 1995. Write in the amount of **untaxed** social security benefits (including Supplemental Security Income) that your parents got in 1995. Don't include any benefits reported in question 67. Don't report monthly amounts; write in the total for 1995. Be sure to include the amounts that your parents got for you and their other children.

73. Aid to Families with Dependent Children (AFDC or ADC) for 1995. Don't report monthly amounts; write in the total for 1995. Don't report social security benefits here.

74. Child support received for all children. Include the student. Don't report monthly amounts; write in the total received for 1995.

75. Other untaxed income and benefits for 1995. Use Worksheet #2 on page 11. Add up your parents' other untaxed income and benefits for 1995. Be sure to include your parents' deductible IRA/Keogh payments, if any.

76. 1995 Total from Worksheet #3. Enter the total amount from Worksheet #3 on page 12. Write in "0" if the worksheet [illegible]s don't apply to your parents.

ATTENTION: COMPLETE WORKSHEET A IF YOU ARE FILLING OUT THE GRAY AND WHITE AREAS OR WORKSHEET B IF YOU ARE FILLING OUT THE RED AND WHITE AREAS TO SEE IF YOU NEED TO FILL OUT SECTION G.

WORKSHEET A—SIMPLIFIED NEEDS TEST

1. Did or will you (and your spouse) file a 1995 IRS Form 1040, and you (and/or your spouse) were not and are not eligible to file a 1995 1040A or 1040EZ?

If "Yes"—fill out Section G, WHITE area, and the rest of this form.

If "No"—fill out the rest of this Worksheet.

Income from the STUDENT (& SPOUSE) column:

2. Question 55 $__________.00
OR
3. Questions 57 and 58 $__________.00
(only if you left question 55 blank)

If the answer from either **question 2 or 3 is less than $50,000**, you do not have to fill out Section G. Go on to Section H.

[illegible]he answer from either **question 2 or 3 is $50,000 or more**, complete [illegible]ction G and the rest of this form.

WORKSHEET B—SIMPLIFIED NEEDS TEST

1. Did or will you and/or your parent(s) (both parents, if they are married) file a 1995 IRS Form 1040, and you and/or your parent(s) were not and are not eligible to file a 1995 1040A or 1040EZ?

If "Yes"—fill out Section G, both WHITE and RED areas, and the rest of this form.

If "No"—fill out the rest of this Worksheet.

Income from the PARENT(S) column only:

2. Question 67 $__________.00
OR
3. Questions 69 and 70 $__________.00
(only if you left question 67 blank)

If the answer from either **question 2 or 3 is less than $50,000**, you do not have to fill out Section G. Go on to Section H.

If the answer from either **question 2 or 3 is $50,000 or more**, complete Section G and the rest of this form.

Section G: Asset Information

Student (& Spouse) Asset Information

You must give information about your (and your spouse's) assets in Section G. If you are divorced or separated and you and your spouse have jointly owned assets, give only your portion of the assets and debts. Be sure to give information about assets held in trust for you (and your spouse).

If you (and your spouse) have assets owned jointly with someone else—such as a business or farm—give only your (and your spouse's) portion of the assets and debts.

In Section G, **don't include:**

- a home, if it is the principal place of residence,
- a family farm, as defined in question 82,
- personal or consumer loans, or any debts that are not related to the assets listed,
- the value of life insurance policies and retirement plans (pension funds, annuities, IRAs, Keogh Plans, etc.), or
- student financial aid.

77. Cash, savings, and checking accounts. Include the current balance of checking or savings accounts unless you (and your spouse) do not have access to the money because the state declared a bank emergency due to the insolvency of a private deposit insurance fund.

78. Other real estate and investments value. If you (and/or your spouse) own other real estate or have investments, write in how much they are worth today. Other real estate includes rental property, land, and second or summer homes. Include the value of portions of multifamily dwellings that are not the family's principal residence. Investments include trust funds, money market funds, mutual funds, certificates of deposit, stocks, bonds, other securities, installment and land sale contracts *(including mortgages held)*, commodities, precious and strategic metals, etc. Don't include your home.

79. Other real estate and investments debt. Write in how much you (and/or your spouse) owe on other real estate and investments.

80. Business value. If you (and/or your spouse) own a business, write in how much the business is worth **today**. Include the market value of land, buildings, machinery, equipment, inventories, etc.

81. Business debt. Write in what you (and/or your spouse) owe on the business. Include only the present mortgage and related debts for which the business was used as collateral.

82. Investment farm value. If you (and/or your spouse) own an investment farm, write in the value **today**. Include the market value of land, buildings, machinery, equipment, livestock, inventories, etc. Don't include a family farm if it is your principal place of residence and you claimed on Schedule F of the tax return that you "materially participated in the farm's operation."

83. Investment farm debt. Write in what you (and/or your spouse) owe on the investment farm. Include only the present mortgage and related debts for which the farm was used as collateral.

Parent(s) Asset Information

You must give information about your parents' assets in Section G. If you are giving information for only one parent and that parent has jointly owned assets, give only that parent's portion of the assets and debts.

If your parents have assets owned jointly with someone else—such as a business or farm—give only your parents' portion of the assets and debts.

In Section G, **don't include:**

- a home, if it is the principal place of residence,
- a family farm, as defined in question 90,
- personal or consumer loans, or any debts that are not related to the assets listed,
- the value of life insurance policies and retirement plans (pension funds, annuities, IRAs, Keogh Plans, etc.), or
- student financial aid.

84. Write in the age of the older parent for whom you are giving information on this form. Refer to page 5 to see whose information you should be reporting on this form.

85. Cash, savings, and checking accounts. Include the current balance of checking or savings accounts unless your parents do not have access to the money because the state declared a bank emergency due to the insolvency of a private deposit insurance fund.

86. Other real estate and investments value. If your parents own other real estate or have investments, write in how much they are worth **today**. Other real estate includes rental property, land, and second or summer homes. Include the value of portions of multifamily dwellings that are not the family's principal residence. Investments include trust funds, money market funds, mutual funds, certificates of deposit, stocks, bonds, other securities, installment and land sale contracts *(including mortgages held)*, commodities, precious and strategic metals, etc. Don't include your parents' home.

87. Other real estate and investments debt. Write in how much your parents owe on other real estate and investments.

88. Business value. If your parents own a business, write in how much the business is worth **today**. Include the market value of land, buildings, machinery, equipment, inventories, etc.

89. Business debt. Write in what your parents owe on the business. Include only the present mortgage and related debts for which the business was used as collateral.

90. Investment farm value. If your parents own an investment farm, write in the value of the farm **today**. Include the market value of land, buildings, machinery, equipment, livestock, inventories, etc. Don't include a family farm if it is the principal place of residence and your parents claimed on Schedule F of the tax return that they "materially participated in the farm's operation."

91. Investment farm debt. Write in what your parents owe on the investment farm. Include only the present mortgage and related debts for which the farm was used as collateral.

Section H: Releases and Signatures

92–103. By answering questions 92 through 103, and signing this form, you give permission to the U.S. Department of Education to provide information from your application to the college(s) that you list in Section H. You also agree that such information is deemed to incorporate by reference the Statement of Educational Purpose on page 4 of the application. Colleges that receive information electronically or on tape or cartridge will get your application information automatically. Colleges use this information to help estimate the amount of your financial aid package. Don't write in the name of a college if you don't want it to receive your application information. You may leave questions 92-103 blank if you don't know which colleges you are interested in, but if you do, we will not send your application information to any colleges.

Your application may be processed faster if you write in the Title IV Code and the name of the college only. Check with your financial aid office, your high school counselor, or your public library for the Title IV Code list provided by the U.S. Department of Education. The Title IV Code is always a ten-character code that begins with "0" (zero), "G," "B," or "E."

If you can't get the Title IV Code, write in the **complete name, address, city, and state** of the college(s) that you are interested in attending. **Write clearly.** It is very important to write the correct city and state or Title IV Code so that your college can be identified. If a college is a branch campus, include the complete name of the branch. Also, indicate if it is a specific part of a university, such as the law school.

For each college, select the housing code number that best describes the type of housing you expect to live in if you attend that particular college. Write the housing code number on the line for that college. In question 92, write in the name and address of the college that you are most likely to attend. (Note: **States often consider the college you write on the first line in determining their awards for state aid.**) In question 93, write in your expected housing code for that college. Continue in the same way for question 94 if you are applying to more than one college. Don't write more than one college and housing code o each line.

To have information sent to more than six colleges. About four weeks after mailing your application, you will receive a Student Aid Report (SAR). You can take or send a copy of your SAR to a new college. You can also write a letter to a FAFSA processor requesting that information be sent to new colleges. Or, after you receive your SAR, you can write in new college names/addresses or Title IV codes on the SAR, and return it to the address printed on the SAR.

104. Answer "No" only if you do **not** give permission to send information from this form to the financial aid agencies in your state and to the state agencies of any college(s) you listed in Section H. Some state agencies use this information to help decide whether you will get a state award and to check if you reported correct information on your state student aid application. Also, they may use it to help in the processing of your application for a Federal student loan, if you are eligible. **If you answer "No," any state aid you might be eligible for may be denied or delayed,** but it will have no effect on your Federal student aid.

By allowing us to send information to your state financial aid agency, you are giving permission to the verification of any statement made on this form. Also, you are giving permission to the state financial aid agency to which information is being sent to obtain income tax information for all persons required to report income and for all periods reported on this form.

Maryland residents only. You are giving permission to have your information sent to your state senator and delegates so that you may be considered for scholarships under their programs, unless you answer **"No."**

[illegible] sure to read Information on the Privacy Act and Use of Your Social Security Number on page 12.

105. Selective Service Registration. In order to receive Federal student aid, you must be registered with Selective Service if you are a male who is at least 18 years old and born after December 31, 1959. Answer **"Yes"** only if you are a male and are 18 through 25 years of age, have not yet registered with Selective Service, **and** give Selective Service permission to register you. If you believe that you are not required to be registered, call the Selective Service office at 1-847-688-6888 for information regarding exemptions.

106–107. Read and sign. You must sign and date this form. If you don't, it will be returned unprocessed. If you are married, your spouse should also sign this form. If you filled out the **RED** and the **WHITE** areas, at least one of your parents must sign this form. **Everyone signing this form is certifying that all information on the form is correct** and that everyone is willing to provide documents to prove that the information is correct. Such documents may include U.S. or state tax returns and the worksheets in this instruction book. Don't sign, date, or mail your FAFSA before January 1, 1996. If you do, the form will be returned unprocessed.

Section I: Preparer's Use Only

[illegible]8-110. Preparers. If someone other than you, your spouse, [illegible] parents completed this form on your behalf, especially if the person charged a fee for assisting you, the law requires the preparer to fill in Section I. A "preparer" is anyone who wrote the answers or told you what to write. The preparer must write in his or her name and the company name and address (or home address, if self-employed). Either the preparer's social security number, or the company's Employer Identification Number (EIN) as assigned by the Internal Revenue Service (IRS), is also required. The preparer must sign and date the form, certifying that the information is correct and complete. An original signature is required, although the preparer may use a preprinted address label or a rubber stamp to fill in address information.

SENDING IN YOUR FORM

Double-check your form to make sure it is complete and accurate. Be sure it has the necessary signatures. Put the form in the envelope provided. Don't send money; this is a free application. Don't put letters, tax forms, worksheets, or any extra materials in the envelope. **They will be destroyed.**

SPECIAL INSTRUCTIONS/DEFINITIONS

Puerto Rico Tax Return. If you, your spouse, and/or your parents filed (or will file) a 1995 Puerto Rico tax return, or were not required to file a Puerto Rico tax return according to the tax code of Puerto Rico, follow the instructions below:

- In question 53 and/or question 65, fill in oval "A" if a Puerto Rico tax return has been filed; oval "C" if a Puerto Rico tax return will be filed; or oval "E" if you, your spouse, and/or your parents were not required to file a Puerto Rico tax return according to the tax code of Puerto Rico.
- Use the information from that tax return to fill out this form.

Foreign Tax Return. If you and your spouse, or your parents, **won't be filing a U.S. income tax return in 1995,** follow the instructions below:

- In question 53 and/or question 65, fill in oval "B" if a foreign tax return has been filed, or oval "D" if a foreign tax return will be filed.
- Use the information from that tax return to fill out this form.
- Convert all figures to U.S. dollars, using the exchange rate that is in effect **today,** and
- Fill out Section G, Asset Information.

Legal Guardian. A legal guardian is a person who is appointed by a court to be your legal guardian in a legal relationship that will continue after June 30, 1997, **and** who is directed by a court to support you with his or her own financial resources.

Native American. If you are a Native American, report the amount of income and assets over $2,000 per individual payment that you (and your spouse) or your parents received in 1995 from the Per Capita Act or the Distribution of Judgment Funds Act. If $2,000 or less per individual payment was received from either of these Acts, don't report it. Don't report funds received as an award under the Alaska Native Claims Settlement Act or the Maine Indian Claims Settlement Act. Also, don't report any assets received from the Alaska Native Claims Settlement Act.

Citizens of the Marshall Islands, Federated States of Micronesia, and Palau. If you do not have a social security number (SSN), contact your financial aid administrator before you mail in this form. Also ask your financial aid administrator how to answer question 15 about your citizenship status.

DRAFT SAMPLE DRAFT

WHAT HAPPENS NEXT?

Need more information on Federal student aid? You can get more information from *The Student Guide: Financial Aid from the U.S. Department of Education.* To get a free copy, write to:

Federal Student Aid Information Center
P.O. Box 84
Washington, DC 20044

The U.S. Department of Education also has a toll-free number to answer questions about Federal student aid programs. This number is **1-800-4-FED AID (1-800-433-3243)**.

If you are hearing-impaired and have a TDD machine, you may call toll-free **TDD 1-800-730-8913**.

What happens after I mail in my form? Within four weeks, the U.S. Department of Education will send you a **Student Aid Report (SAR).** On the SAR will be either a request for further information or a number called an **Expected Family Contribution (EFC).** We use a formula established by law to figure the EFC from the information you give us. Your college uses the EFC to determine the amount of your Federal grant, loan, or work-study award, if you are eligible.

Your college or the U.S. Department of Education may ask you to prove that the information you gave on your application is true. Be sure to make a copy of your application form before mailing it.

What if I don't get a SAR or I need another copy of my SAR? If you don't get a SAR within four weeks, call this Federal student aid information number, **1-319-337-5665.** You can find out if your application has been processed, or you may request duplicate copies of your SAR.

What if my situation changes? Some questions ask you to make projections, for example, about your family status for the coming year. If your answers to these questions change, wait until you receive your SAR, then check with your financial aid administrator. The income and expense information reported on this form must be accurate for the past year (1995), not for the coming year. If your financial situation changes, check with your financial aid administrator.

How long does it take to complete this application? The time required to complete this information collection is estimated to vary from one hour to one hour and thirty minutes, including the time to review instructions, search existing data resources, gather and maintain the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, DC 20202-4651. If you have any comments or concerns regarding the status of your individual submission of this form, write directly to: Application and Pell Processing Systems Division, U.S. Department of Education, 600 Independence Avenue, S.W., Washington, DC 20202.

DEADLINES FOR STATE STUDENT AID

AL	Check with your financial aid administrator
AK	Check with your financial aid administrator SSIG - May 31, 1996
•AS	Check with your financial aid administrator
AZ	June 30, 1997 - date received
AR	April 15, 1996 - date received
•CA	March 2, 1996 - date postmarked
CO	Determined by school
•CT	Check with your financial aid administrator
DE	April 15, 1996 - date received
•DC	June 24, 1996 - date received by state
FL	May 15, 1996 - date processed
GA	Determined by school
•GU	Check with your financial aid administrator
HI	March 1, 1996
ID	Determined by school
IL	For first-time applicants - October 1, 1996 For continuing applicants - June 1, 1996 date processed
IN	March 1, 1996 - date postmarked
IA	April 19, 1996 - date received
•KS	For priority consideration - April 1, 1996 - date processed OR March 15, 1996 - date received
KY	For priority consideration - March 15, 1996
LA	March 15, 1996 - date postmarked OR April 1, 1996 - date received Check with your financial aid administrator
•ME	May 1, 1996 - date received
MD	March 1, 1996 - date postmarked
MA	For priority consideration - May 1, 1996 date received
MI	HS Seniors - February 21, 1996 College students - March 21, 1996 Date received
MN	May 1, 1997 - date received
MS	Determined by school
MO	April 30, 1996 - date received
MT	For large schools - March 1, 1996 For small schools - April 1, 1996
•NE	Determined by school
•NV	Determined by school
NH	May 1, 1996 - date received
NJ	1995-96 Tuition Aid Grant Recipients- June 1, 1996 All other applicants - October 1, 1996 for fall & spring terms March 1, 1997 for spring term only date received
NM	Determined by school
•NY	May 1, 1997 - date postmarked
NC	March 15, 1996 - date received
ND	April 15, 1996 - date processed
OH	October 1, 1996 date received
OK	April 30, 1996 - date received
OR	None - contingent on funding - date received
•PA	All 1995-96 State grant recipients - May 1, 1996 Non-1995-96 State grant recipients enrolling in degree programs - May 1, 1996 All other applicants - August 1, 1996 date received
PR	May 2, 1997 - date application signed
RI	March 1, 1996 - date received
•SC	June 30, 1996 - date received
•SD	Determined by school
TN	May 1, 1996 - date processed
•TX	Determined by school
UT	Determined by school
•VT	None
•VI	Check with your financial aid administrator
•VA	Determined by school
WA	Determined by school
•WV	March 1, 1996 - date received
WI	None - contingent on funding
•WY	Determined by school
•FM	Check with your financial aid administrator
•MH	Check with your financial aid administrator
•MP	Check with your financial aid administrator
•PW	Check with your financial aid administrator

- Additional form may be required. Contact your financial aid administrator or your state agency.

Note: Date received means "at the address on this form."

DRAFT SAMPLE DRAFT

WORKSHEET #1 *(Keep this worksheet. Your college may ask to see it.)*

	For question 55 Student/Spouse	**For question 67 Parent(s)**
Wages, salaries, tips, etc	$__________.00	$__________.00
Interest income	+__________.00	+__________.00
Dividends	+__________.00	+__________.00
Other taxable income (alimony received, business and farm income, capital gains, pensions, annuities, rents, unemployment compensation, Social Security, Railroad Retirement, and all other taxable income)	+__________.00	+__________.00
Add all of the numbers in the column	=__________.00	=__________.00
Subtract IRS-allowable adjustments to income (payments to IRA and Keogh Plans, one half of self-employment tax, self-employed health insurance deduction, interest penalty on early withdrawal of savings, and alimony paid)	–__________.00	–__________.00
TOTAL—Write this amount in question 55 and/or 67:	$__________.00	$__________.00

WORKSHEET #2 *(Keep this worksheet. Your college may ask to see it.)*

Amounts from IRS tax forms	**For question 63 Student/Spouse**	**For question 75 Parent(s)**
Deductible IRA and/or Keogh payments from Form 1040-total of lines 23a, 23b, and 27 or 1040A-line 15c	$__________.00	$__________.00
Untaxed portions of pensions from Form 1040-line 15a minus 15b and 16a minus 16b or 1040A-line 10a minus 10b and 11a minus 11b (excluding "rollovers")	+__________.00	+__________.00
Credit for Federal tax on special fuels from IRS Form 4136 - Part III: Total Income Tax Credit (non-farmers only)	+__________.00	+__________.00
Foreign income exclusion from Form 2555-line 43 or Form 2555EZ-line --	+__________.00	+__________.00
Tax exempt interest income from Form 1040-line 8b or 1040A-line 8b	+__________.00	+__________.00
Other Untaxed Income and Benefits		
Payments to tax-deferred pension and savings plans (paid directly or withheld from earnings) as reported on the W-2 Form. Include untaxed portions of 401(k) and 403(b) plans	+__________.00	+__________.00
Welfare benefits (except AFDC or ADC, which you should have reported in FAFSA question 61 or 73)	+__________.00	+__________.00
Workers' Compensation	+__________.00	+__________.00
Veterans noneducation benefits such as Death Pension, Dependency & Indemnity Compensation (DIC), etc	+__________.00	+__________.00
Housing, food, and other living allowances (excluding rent subsidies for low-income housing) paid to members of the military, clergy, and others (including cash payments and cash value of benefits)	+__________.00	+__________.00
Cash or any money paid on your behalf, not reported elsewhere on this form	+__________.00	XXXXXXXXXX
Any other untaxed income and benefits, such as Black Lung Benefits, Refugee Assistance, or untaxed portions of Railroad Retirement Benefits	+__________.00	+__________.00
TOTAL—Write this amount in question 63 and/or 75:	$__________.00	$__________.00

Don't include:

- Social Security
- Any income reported elsewhere on the form
- Money from student financial aid
- Food stamps
- "Rollover" pensions
- JTPA benefits
- Gifts and support, other than money, received from friends or relatives
- Veterans educational benefits (GI Bill, Dependents Education Assistance Program, VA Vocational Rehabilitation Program, VEAP benefits, etc.)
- Payments received from states for foster care and adoption assistance, under title IV-A or IV-E of the Social Security Act

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DRAFT SAMPLE DRAFT

WORKSHEET #3 *(Keep this worksheet. Your college may ask to see it.)*

(Note: On this worksheet, use amounts received during the **calendar year from January 1, 1995 to December 31, 1995**, rather than amounts received during the school year.)

	For question 64 Student/Spouse	**For question 76 Parent(s)**
1. Grant and scholarship aid in excess of tuition, fees, books, and required supplies that you reported or will report on your 1995 income tax return (FAFSA questions 55 and/or 67) and/or as your earned income (FAFSA questions 57–58 and/or 69–70)	$______.00	$______.00
2. Earnings from Federal Work-Study or other need-based work programs	+______.00	+______.00
3. Allowances and benefits received under the National and Community Service Trust Act of 1993	+______.00	+______.00
4. Child support **PAID** because of divorce or separation, by student & spouse, or by the parent(s) whose income is reported on this form. (Do not include support for children living in your home.)	+______.00	+______.00
TOTAL—Write this amount in question 64 and/or 76:	$______.00	$______.00

INFORMATION ON THE PRIVACY ACT AND USE OF YOUR SOCIAL SECURITY NUMBER

The Privacy Act of 1974 requires that each Federal agency that asks for your social security number or other information must tell you the following:

1. Its legal right to ask for the information and whether the law says you must give it.
2. What purpose the agency has in asking for it and how it will be used.
3. What could happen if you do not give it.

You must give your social security number (SSN) to apply for Federal student financial aid. The U.S. Department of Education's legal right under the Title IV programs to require that you provide us with your SSN is based on Section 484(a)(4)(B) of the Higher Education Act of 1965, as amended. The SSN is used under the Federal Pell Grant, Federal Supplemental Educational Opportunity Grant, and Federal Work-Study programs in recording information about your college attendance and progress, and in making sure that you have received your money. The SSN is also used under the Federal Family Education Loan, Federal Direct Student Loan, and Federal Perkins Loan programs to identify the applicant, to determine program eligibility and benefits, and to permit servicing and collecting of the loans.

If you are applying for Federal student aid only, you must fill out everything except questions 12, 18, 20-21, 22-23, 24-28, 29, 30, 31, 32, 50, 92-103, 104, and 105. If you wish to be considered for state student aid, you must fill out all of the questions, and do not answer "No" to question 104. The authority to request all other information (except the SSN) is based on sections 474, 475, 476, 477, 479, 480, and 483 of the Higher Education Act of 1965, as amended. This information is used to determine the amount of Federal student aid for which you may be qualified.

The information which you supplied may be disclosed to third parties that the Department has authorized to assist in administering Federal student aid programs. This disclosure may include private firms that the Department contracts with for the purpose of collating, analyzing, totalling or refining records in the system and who are required to maintain safeguards under the Privacy Act. This may also be accomplished through computer matching programs with other Federal agencies for verification of information as to eligibility for benefit programs, debt collection and the prevention of fraud, waste, and abuse. For example, such computer matching programs include the ones conducted with the Selective Service System, the Social Security Administration, and the Immigration and Naturalization Service, and in cooperation with the Department of Justice to enforce Section 5301 of the Anti-Drug Abuse Act.

We will provide your name, address, social security number, date of birth, expected family contribution number, student status, and state of legal residence to the financial aid agency(ies) in your state of legal residence, even if you answer "No" in question 104. This information will go to the state agencies in your state of legal residence to help coordinate state financial aid programs with Federal student aid programs. We will also provide your application information to the college(s) you listed in Section H, or its representative. We will also send your information to the financial aid agency(ies) in the state(s) in which the college(s) is located, but only if you do not answer "No" in question 104. We will provide calculations and determination of eligibility to the agency with which you filed a student aid application, or another similar agency, if you request us to do so. That agency may also release information received from the Department to colleges, state scholarship agencies, and loan guaranty agencies that you have designated to receive information. Also, we may send information to members of Congress if you ask them to help you with Federal student aid questions. If your parents or your spouse provided information on the form, they may also request to see all the information on the application (as covered by their certification).

If the Federal government, the Department, or an employee of the Department is involved in litigation, we may send information to the Department of Justice, or a court or adjudicative body, if the disclosure is related to financial aid and certain other conditions are met. The information may also be made available to Federal agencies which have the authority to subpoena other Federal agencies' records. In addition, we may send your information to a foreign, Federal, state, or local enforcement agency if the information that you submitted indicates a violation or potential violation of law, for which that agency has jurisdiction for investigation or prosecution. Finally, we may send information regarding a claim which is determined to be valid and overdue to a consumer reporting agency. This information includes identifiers from the record, the amount, status and history of the claim and the program under which the claim arose.

REMEMBER, WE MUST RECEIVE YOUR APPLICATION BY JUNE 30, 1997.

[illegible]	How to Apply	Eligibility Requirements	Range of Awards
[illegible]	[illegible]	1. Demonstrated financial need. 2. Enrolled in degree or certificate program. 3. U.S. citizen or eligible noncitizen. 4. Undergraduate. 5. Maintain satisfactory academic progress.	Varies depending upon enrollment status and family contribution. Range $400 - $2300
[illegible]	[illegible] Application for Federal Student Aid. [illegible] Financial Aid Application.	1. PA resident. 2. Enrolled 6 credits or more. 3. Enrolled in 2-year degree program. 4. Demonstrated financial need. 5. Maintain satisfactory academic progress.	Varies depending upon need Range: $200-80% of tuition and fees.
[illegible]	1. Free Application for Federal Student Aid. 2. CCAC Financial Aid Application.	1. Must have a completed financial aid file by May 1st. (Refer to "How to Apply") 2. Demonstrated financial need. 3. Enrolled in a degree or certificate program. 4. U.S. citizen or eligible noncitizen. 5. Undergraduate. 6. Maintain satisfactory academic progress.	Varies depending upon need and availability of funding.
[illegible]	1. Free Application for Federal Student Aid. 2. CCAC Financial Aid Application.	1. Demonstrated financial need. 2. Enrolled for 6 or more credits in degree or certificate program. 3. U.S. citizen or eligible noncitizen. 4. Allegheny County resident. 5. Undergraduate. 6. Maintain satisfactory academic progress.	Varies depending [illegible] and availability of [illegible] Maximum Award: [illegible] Tuition and fees [illegible]
[illegible]			
[illegible]	[illegible]	1. Returning student who has completed minimum of 30 credits. 2. Based upon grade point average and/or extracurricular activities. 3. Enrolled for 6 or more credits.	Maximum Award: [illegible]
[illegible]			
[illegible]	1. [illegible] Application for Federal Student Aid. 2. CCAC Financial Aid Application. 3. Campus Employment Application.	1. Demonstrated financial need. 2. Enrolled in degree or certificate program. 3. U.S. citizen or eligible noncitizen. 4. Maintain satisfactory academic progress.	Varies depending upon need and availability of funding. Wages paid on hourly basis at minimum wage.

Loans	How to Apply	Eligibility Requirements	Range of Awards
[illegible]	1. Free Application for Federal Student Aid 2. CCAC Financial Aid Application 3. Federal Stafford Loan Application (available from local banks, savings and loan associations and credit unions).	1. U.S. citizen or eligible noncitizen. 2. Enrolled for 6 or more credits in degree or certificate programs. 3. Must attend Pre-Loan Counseling/Entrance Interview. 4. Maintain satisfactory academic progress. 5. Lenders extend the benefits of an Unsubsidized Federal Stafford Loan to eligible Federal Stafford Loan applicants who do not meet the federal financial need analysis standards for the subsidized Federal Stafford Loan. The student must pay interest during the period he/she is in school for the Unsubsidized Stafford Loan.	Range: Up to $2,625 for Grade Level 1*, $3,500 for Grade Level 2.* Repayment begins six months after termination of studies. Interest rate varies depending on borrower's status. * Unsubsidized Stafford Loan amounts may vary.
[illegible]	1. Loan Application (available from local banks, savings and loan associations and credit unions). 2. CCAC Financial Aid Application 3. Free Application for Federal Student Aid	1. Parent of dependent student. 2. Student must be U.S. citizen or eligible noncitizen. 3. Student must enroll for 6 or more credits in degree or certificate program. 4. Student must have high school diploma. 5. Student must maintain satisfactory academic progress.	Range: Cost less other aid. Repayment begins 60 days after loan is disbursed. Subject to credit check by lender.
[illegible]	1. Free Application for Federal Student Aid 2. CCAC Financial Aid Application.	1. Demonstrated financial need. 2. U.S. citizen or eligible noncitizen. 3. Maintain satisfactory academic progress. 4. Must have complete Financial Aid file by May 1st. (Refer to "How to Apply").	Varies depending upon need and availability of funding. Range: $200 - $1800 Repayment at 5% interest nine months after termination of studies.
[illegible]	1. Free Application for Federal Student Aid. 2. CCAC Financial Aid Application.	1. Demonstrated financial need. 2. U.S. citizen or eligible noncitizen. 3. Maintain satisfactory academic progress. 4. Must have completed Financial Aid file by May 1st. (Refer to "How to Apply").	Varies depending upon need and availability of funding. Repayment at 5% interest nine months after termination of studies.

CCAC

It is the policy of the Community College of Allegheny County not to discriminate in its programs of education, employment and all other activities on the basis of race, color, national origin, religion, sex, age and handicap. Any complaints of discrimination should be directed to: Affirmative Action Officer, Community College of Allegheny County, 800 Allegheny Avenue, Pittsburgh, PA 15233. Telephone No. (412) [illegible].

ELIGIBILITY REQUIREMENTS AND FUNDING FOR THESE PROGRAMS ARE SUBJECT TO CHANGE WITHOUT NOTICE.

University of Pittsburgh
Medical Center

Western Psychiatric Institute and Clinic

204 Iroquois Building
3600 Forbes Avenue
Pittsburgh, PA 15213-3410
412-624-2842

**Psychiatric Rehabilitation and
Assessment Services**

MEMORANDUM

TO: PRAS staff

FROM: Michelle Geckle, M.Ed., CRC MG

DATE: October 7, 1994

RE: Student loan deferments

As you may be aware, PRAS clinicians are able to sign rehabilitation deferments for our clients with previous student loans (#8 on the attached list). It is important to analyze on a case-by-case basis if the deferment is in a client's best interest. On some loans, the interest continues to accrue during the deferment period. Clients can call the Student Loan Servicing Center (S.L.S.C.) at 1-800-233-0557 to determine the type of loan they possess and to request deferment forms. Clients can also complete the attached form to request a rehabilitation deferment.

PHEAA
1-800-692-7435 - Grants
1-800-692-7392 - Loans

The Federal Student Aid Center (PELL)
1-800-433-3243
8am-7pm, M-F, Central Standard Time

STUDENT LOAN SERVICING CENTER

P.O. Box 2461 - correspondance
Harrisburg, Pennsylvania 17105-2461 17105-2461
TOLL FREE - 1-800-233-0557

DEFERMENT INFORMATION

When your grace period expires and your repayment period begins you are entitled to have monthly installment payments of principal deferred during authorized periods. Federal regulations require you to provide all documentation needed to establish eligibility for a specific deferment. REMEMBER: Deferments are NOT automatic, and eligibility is based on the loan program through which you obtained your loan and/or the disbursement date of your loan. Additional information may be needed to grant your request. We will send you the appropriate forms which you must complete and return. You will be notified of approval or denial as soon as possible. Please READ THE ENTIRE FORM CAREFULLY TO ENSURE ELIGIBILITY. A deferment is granted for periods during which you are engaged in one of the following activities:

(Please Check One)

____ 1. Return to full-time study at an eligible educational institution.

____ 2. Study at an eligible, Federally-run institution of higher education or vocational school.

____ 3. Study under an eligible Graduate Fellowship Program.

____ 4. Active duty in U.S. Armed Forces or as an officer in Public Health Service.

____ 5. Volunteer service under the Peace Corps Act.

____ 6. Volunteer service under Title I (ACTION Program).

____ 7. Volunteer service for a Tax Exempt Organization.

____ 8. Enrollment in a Rehabilitation Training Program.

____ 9. Service in an eligible Internship or Residency Program.

____ 10. If you or your spouse is Temporarily/Totally Disabled.

____ 11. If you are a "Single Parent" and must provide continuous care for a disabled dependent. Disability must last for at least three months.

____ 12. Pregnant or caring for your newborn or newly adopted child. You must have been enrolled at least half-time in the last six months prior to receiving the deferment. You may not work or go to school while on deferment.

____ 13. Unemployed and seeking full-time employment. To qualify for this deferment Federal regulations require that you:

    a) Are unemployed or working less than 30 hours per week.

    b) Be registered with an employment agency (public or private) that helps you obtain employment in any field.

Are able to list three attempts to secure employment in the past three months including the name and address or the firm, person contacted, and the date.

THE FOLLOWING DEFERMENTS ARE AVAILABLE ONLY TO NEW STUDENT BORROWERS WHO OBTAINED THEIR FIRST LOAN TO ATTEND SCHOOL FOR AN ENROLLMENT PERIOD BEGINNING ON OR AFTER JULY 1, 1987:

____ 1. Return to half-time study at an eligible educational institution and has borrowed a Guaranteed Student Loan for the loan period covered by the deferment.

____ 2. Service in the National Oceanic and Atmospheric Administration Corp.

____ 3. Teaching in "Shortage Areas". You may teach in an elementary or secondary school in a "Shortage Area" as defined by the Secretary of Education. Shortage refers to both geographic and subject area.

____ 4. Mother of a pre-school aged child. Must be entering or reentering the work force and be paid at a rate not more than $1 above the Federal Minimum Wage.

AVAILABLE TO ALL BORROWERS

If you do not qualify for any of the above statutory deferments, and yet your current financial situation makes it difficult to meet your student loan obligation, you may be eligible for a Forbearance. During Forbearance, you are required to pay only the interest that accrued on your account. Any unpaid interest may (at your lender's discretion) be added to and become part of the principal of the loan at the end of the Forbearance period. This is called Capitalization. If you feel you qualify for Forbearance, please complete the following:

1. You are currently employed full-time? ____

   or less than 30 hours per week? ____

2. Place of employment: ____________________

3. What is your net income per month? ____________________

4. List all monthly expenditures (i.e., Rent, Mortgage, Utilities, etc.)

   ________ ________ ________ ________ ________

   ________ ________ ________ ________ ________

5. Length of time for which you wish to be granted Forbearance:

   Maximum of 24 months granted in 6 month intervals. ____ (6 months)

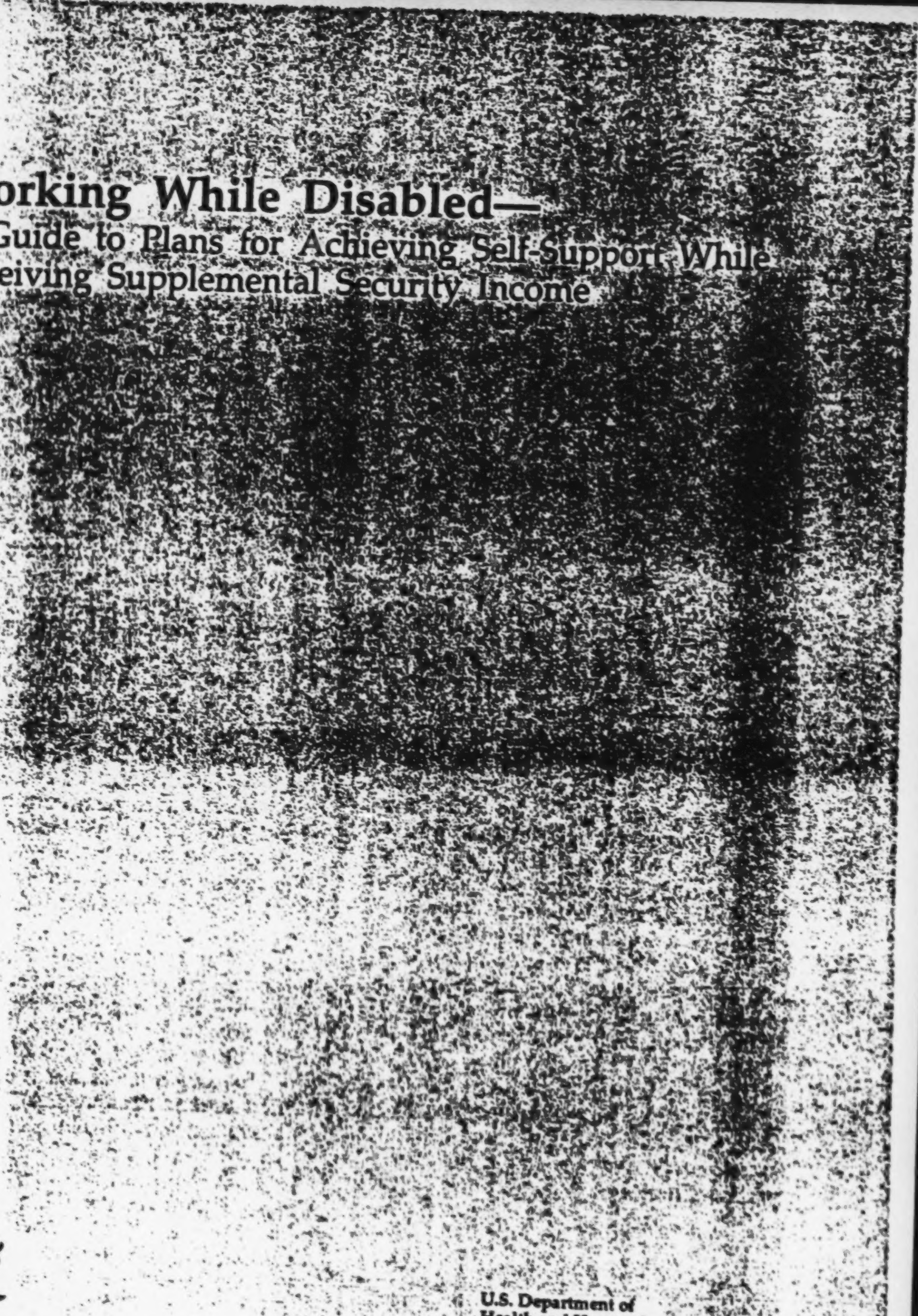
Please sign and return this request form in the space provided below and return it to the Student Loan Servicing Center at the above address within 30 days.

____________________ Name (PLEASE PRINT)	____________________ Social Security Number
____________________ Signature	____________________ Date

BEST COPY AVAILABLE

Working While Disabled—

A Guide to Plans for Achieving Self-Support While Receiving Supplemental Security Income



U.S. Department of
Health and Human Services
Social Security Administration
SSA Publication No. 05-11017
August 1991
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What is a plan for achieving self-support?

Basically, a plan for achieving self-support, or PASS for short, is a plan for your future. Many people with disabilities want to work, and you're probably one of them. But maybe you need to go back to school before you can get a job. Or maybe you'd like to start your own business, but you just don't have the money. Whatever your work goal may be, a PASS can help you reach it.

A PASS lets you set aside money and/or other things you own to help you reach your goal. For example, you could set aside money to start a business or to go to school or to get training for a job.

If you're already getting Supplemental Security Income (SSI), having a PASS means you'll be able to keep more of your SSI payment each month. If you don't get SSI because your income or resources are too high, setting up a PASS may help you qualify. And that can be very important because people who get SSI usually get Medicaid, too.

How will a plan affect my SSI checks?

Under regular SSI rules, your SSI check is reduced by the other income you have. But the income you set aside for a PASS **doesn't** reduce your SSI check. This means you can get a higher SSI benefit when you have a PASS. But you can't get more than the maximum SSI benefit for the State where you live.

Money you save or things you own such as property or equipment that you set aside for a PASS won't count against the resource limit of $2,000 (or $3,000 for a couple). Under regular SSI rules, you wouldn't be eligible for SSI if your resources are above $2,000. But with a plan, you may set aside some resources so you would be eligible for SSI.

Who can have a plan?

You can, if you:
- Get SSI (or can qualify for SSI) because of blindness or a disability;

AND
- Have or expect to receive income (other than SSI) and/or resources to set aside toward a work goal.

And remember: If you don't get SSI now, having a PASS may help you qualify.

What kinds of expenses can a plan help pay for?

A plan may be used to pay for just about any expenses that will help you reach your work goal. For example, your plan may help you save for:
- Supplies to start a business;
- Tuition, fees, books, and supplies needed for school or training;
- Supported-employment services, including payments for a job coach;
- Attendant care or child care expenses;
- Equipment and tools to do the job;
- Transportation to and from work; and
- Uniforms, special clothing, and safety equipment.

These are only examples. Not all of these will apply to every plan. You might have other expenses depending on your goal.

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How do I set up a plan?

Your plan must be in writing and approved by Social Security. This chart shows the steps you should follow to set up your plan.

1 Choose a work goal. The goal **must be** a job. It should be a job you're interested in doing and that you think **you'll be able to do** at the end of your plan.

2 Find out how long it will take to reach your goal.

Note: A plan should not last longer than 3 years. But if your plan involves school or training, it may last up to 4 years.

3 Decide what things (such as training or tools) you will need to reach the goal.

Note: Each person will need different things to reach the goal. For example, if you want to work in a restaurant, you may need training to learn how to cook. If you want to become a computer programmer, you may need a college degree and a computer in order to reach your goal. If you want to start a business, you may need to rent a store or office and buy equipment and supplies.

4 Find out the cost of the things you need to reach your goal.

5 Find out how much money you'll need to set aside each month to pay for them. Plan a way to keep receipts for the things you need.

Note: If you're setting aside income, your SSI benefit will usually increase to help pay your living expenses. The people at Social Security can estimate what your new SSI amount will be if you set up your plan.

6 Make plans to keep any money you save for the goal **separate** from any other money you have. The easiest way to do this is to open a separate bank account for the money you save under your plan. But you don't have to open a separate account. Just be sure you can tell us how you're keeping it separate.

7 Write the plan, sign, and date it.

8 Bring or mail the plan to your local Social Security office.

Who may help me set up a plan?

Anybody can help. You may set up a plan yourself or get help from:
- a vocational rehabilitation counselor;
- an organization that helps people with disabilities;
- an employer;
- a friend or relative; or
- the people at your Social Security office.

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How do I write a plan?

There is no required form for a plan. You may simply write a letter that gives all the information about your plan. Or, to make sure your plan is complete, you may use the sample outline on the last page of this pamphlet. Pages 7 and 9 show examples of completed plans using the sample outline. Page 11 explains how to complete the sample outline.

What does Social Security do after I submit my plan?

After you submit your plan, Social Security will:

- review the plan to make sure it is complete;
- decide if there is a good chance that you can reach your goal;
- decide if any changes are needed and discuss those changes with you; and
- send you a letter to tell you if the plan is approved or denied.

If your plan is approved, Social Security will contact you from time to time to make sure that you are doing what your plan says you will do to reach your goal.

What happens if my plan is not approved?

If your plan is not approved, you have a right to appeal the decision. The letter you'll get will explain your appeal rights and tell you what you need to do to appeal. **You may also submit a new plan to Social Security.**

Can I change my plan after it is approved?

Yes. You must tell the Social Security office **in writing** what changes you want to make, such as a change in how much money you set aside each month or additional expenses you will have. The Social Security office will tell you whether the changes are approved. The changes must be approved in advance. It is very important that you tell Social Security as soon as possible about any changes that might affect your plan.

What happens if I cannot complete my plan?

If you cannot complete your plan, you may set up a new plan with a new work goal. If you don't set up a new plan, any money or other things set aside under the original plan **may** begin to count toward the $2,000 resource limit. If they put you over the limit, you may become ineligible for SSI.

Also, Social Security will begin to count the income you were setting aside under the plan. However, as long as you tell Social Security as soon as possible that you cannot complete your plan, you won't have to pay back any extra SSI you got while you were following your plan.

How will a plan affect other benefits I get?

You should check with the agency that is responsible for your other benefits to find out if the plan (and the extra SSI) might affect those benefits.

Are there any other rules that may help?

Yes. Other SSI rules may help you while you work. They can help you keep more of your SSI check, and they can help you keep your Medicaid. There are also some special rules for students. For more information, ask Social Security for the booklet, *Working While Disabled—How Social Security Can Help.*

For more information

If you want more information or if you want to make an appointment with a Social Security representative, just give us a call. Our telephone number is listed in your telephone book under "Social Security Administration" or "U.S. Government."

Examples of plans

Every plan is different. The following two pages show examples of plans.

Example 1 is a plan for Thomas Kelly. Mr. Kelly gets a $227 SSI check and a $200 Social Security disability check each month. He wants to become a cook. He discusses his goal with his counselor, who tells him that he will need 6 months of training which will cost $600. He decides that he wants to use $100 of his Social Security disability check each month to pay for the training. His plan is on the next page.

Once Mr. Kelly's plan is approved, the $100 he sets aside each month to pay for his tuition won't count against his SSI. Therefore, his SSI will go up by $100. This will help him pay his other living expenses.

Example 2 is a plan for Mary Arnold. Mrs. Arnold gets a monthly Social Security disability check of $500. Her income is too high for her to get SSI. She has a chance to go to work for a pottery shop, but she cannot afford to pay for the training and tools she will need and still pay for her living expenses. She discusses the idea with an organization that helps people with disabilities. The people in the organization tell Mary that she may be able to set up a plan to use part of her Social Security disability check to pay for a pottery instructor and pottery tools.

If Mrs. Arnold's plan is approved, the $200 per month she is using toward her work goal won't count when Social Security figures if she can get SSI. Therefore, she'll be eligible for an SSI payment while she's working toward her goal.

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Plan for Achieving Self-Support

Name Thomas Kelly SSN 999-99-9999

1. My work goal is: Cook

2. I want my plan to begin in: October 1990 (month and year)

I expect to reach my goal in: March 1991 (month and year)

3. I will have the following expenses in order to reach my goal:

Item	***Connection to Goal***	***Month(s) Paid***	***Cost***	***Total***
Tuition-- Culinary Academy	Training needed to learn job	10/90 - 3/91	$100 per month	$600

4. I already have the following money or property that I will use to reach the goal:

NONE

5. I expect to receive the following income that I will use to reach the goal:

$100 per month from my Social Security disability check

6. I will keep the money I set aside under my plan in the following bank account:

None -- I will pay the money toward my tuition each month.

7. I ~~am~~/am not already working or saving toward the goal.

8. Signature ______________________ Date ______________

9. Individual(s) who helped me with the plan:

JOHN JONES, Office of Vocational Rehabilitation

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Plan for Achieving Self-Support

Name Mary Arnold SSN 987-65-4321

1. My work goal is: pottery maker

2. I want my plan to begin in: January 1991 (month and year)

I expect to reach my goal in: December 1991 (month and year)

3. I will have the following expenses in order to reach my goal:

Item	*Connection to Goal*	*Month(s) Paid*	*Cost*	*Total*
Payments to pottery instructor	to learn how to make pottery	1/91 - 8/91	$50 per month	$400
pottery tools & supplies	required by employer	1/91 - 12/91	$150 per month	$1,800

4. I already have the following money or property that I will use to reach the goal:

None

5. I expect to receive the following income that I will use to reach the goal:

I will pay $50 per month out of my Social Security check for my lessons. I will save $150 per month from January through December for the tools I will need.

6. I will keep the money I set aside under my plan in the following bank account:

If my plan is approved, I'll open an account at the XYZ Bank.

7. I ~~am~~/am not already working or saving toward the goal.

8. Signature ______________________ Date ______________

9. Individual(s) who helped me with the plan:

Nancy Franklin from the Organization for People with Disabilities

How to complete the PASS outline

If you decide to use the sample outline, fill in your name and your Social Security number in the spaces at the top of the outline. Complete the rest of the outline as follows:

- Line 1: Write your work goal. Be as specific as possible.

- Line 2: Show the month and year when you want your plan to begin. This should be the month when you'll start setting money aside to reach your goal. Next, show the month and year you expect to reach your work goal.

- Line 3: List each of the items you'll need to pay for in order to reach your goal. Show how each item will help you reach your goal and show the months in which you'll set aside the money to pay for them. Also, show how much each item costs. Some items, such as training, may have an hourly, weekly, or monthly cost. If so, show this and the total cost.

- Line 4: Show any resources you own **now** (for example, money in a bank account) that you'll use to pay for the items listed in line 3. If you don't have any resources or don't plan to use them for this purpose, show "None."

- Line 5: Show any income you expect to get in the future **other than your SSI** that you'll use to pay for the items listed in line 3. If you won't use future income, show "None."

  Note: You must have some form of income or resources to use to pay for the items in line 3. If you don't, a PASS won't help you.

- Line 6: If you intend to save money to pay for the items in line 3, you must keep the money you save separate from any other money you have. If you open a bank account to do this, show the name of the bank and the account number. If you don't intend to open a bank account, show how you will keep the money saved under the plan separate from your other money.

- Line 7: Indicate whether or not you are already working toward the goal or saving money toward the goal. If so, show the month you started.

- Line 8: Sign your name and write the date you signed the plan.

- Line 9: Show the name and address of any person or organization who helped you develop your plan.

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Plan for Achieving Self-Support

Name ______________________________ SSN ______________

1. My work goal is: ______________________________

2. I want my plan to begin in: ______________

   I expect to reach my goal in: ______________ (month and year)

3. I will have the following expenses in order to reach my goal:

Item	*Connection to Goal*	*Month(s) Paid*	*Cost*	*Total*

4. I already have the following money or property that I will use to reach the goal:

5. I expect to receive the following income that I will use to reach the goal:

6. I will keep the money I set aside under my plan in the following bank account:

7. I am/am not already working or saving toward the goal.

8. Signature ______________________ Date ______________

9. Individual(s) who helped me with the plan:

U.S. GOVERNMENT PRINTING OFFICE [illegible]

DESIGNED FOR SOCIAL SECURITY BENEFICIARIES WITH
DISABILITIES AND THEIR SUPPORTERS

A STEP-BY-STEP GUIDE
TO WRITING A
PLAN FOR ACHIEVING SELF SUPPORT
FOR SUBMISSION TO THE
SOCIAL SECURITY ADMINISTRATION

THE COMMUNITY REHABILITATION DIVISION
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Step-by-Step Guide

A LITTLE BACKGROUND.......

Work incentives were initially introduced in 1972 with the Amendments to the Social Security Act. Several work incentives have been added since, each time as a result of Congressional concern over the low numbers of people with disabilities who were returning to the work force. The Plan for Achieving Self-Support provision is part of the original supplemental security income statute. When this program was initially developed, Congress expressed a "....desire to provide every opportunity and encouragement to the blind and disabled to return to gainful employment" (FR, 8/87).

This Guidebook was developed with the hope of assisting and encouraging SSI and SSDI beneficiaries to access Social Security Work Incentives and to realize the advantages of working while still being able to collect their benefits. While the situation is improving, the PASS program remains highly underutilized. It is our hope that this Guidebook will be helpful in introducing the Social Security Work Incentive Programs to individuals with disabilities as well as their supporters.

FIRST, A FEW DEFINITIONS......

Social Security Disability Insurance (SSDI) -

Social security benefits for people who have a medical disability and have worked and contributed to social security taxes (F.I.C.A.) for enough terms to be covered under social security disability provisions.

Supplemental Security Income (SSI) -

Social security benefits for people who have a medical disability and little or no income or resources. Maximum SSI income is called the Federal Benefit Rate.

Trial Work Period -

A 9-month period (not necessarily consecutive) during which a disabled or blind Social Security beneficiary's earnings will not affect his or her benefit. (The 9 months of work must occur within a 60-month period.)

Extended Period of Eligibility -

For at least 3 years after a successful trial work period, a disabled or blind Social Security beneficiary may receive a disability check for any month that his or her earnings are below the substantial gainful activity level (in 1993, $500 for disabled, $880 for blind).

Continuation of Medicare -

If Social Security disability payments stop because a person has earnings at or above the substantial gainful activity level, but the person is still disabled, Medicare can continue for at least 39 months after the trial work period. After that, the person can buy Medicare coverage by paying a monthly premium.

Impairment-Related Work Expense -

Certain expenses for things a disabled person needs because of his/her impairment in order to work may be deducted when counting earnings to determine if the person is performing substantial gainful activity.

Continuation of Medicaid Eligibility -

Medicaid may continue for disabled or blind SSI recipients who earn over the SSI limits if the person cannot afford similar medical care and depends on Medicaid in order to work.

Plan for Achieving Self-Support -

A disabled or blind SSI recipient may set aside income and resources for up to 48 months toward an approved Plan for Achieving Self-Support (PASS).

Federal Benefit Rate -

Minimum monthly income level, as determined by each state. As of January 1, 1994, the Federal Benefit Rate is $446.00 per month for Arizona residents. Some states supplement the Federal Benefit Rate.

Substantial Gainful Activity (SGA) -

The performance of significant physical and/or mental activities in work for pay or profit. Applies to SSDI in determining initial and continuing entitlement (<$200 per month for 9 months of trial work period; <$500 per month after trial work period). Applies to SSI only in determining initial eligibility for SSI disability payments (<$200 per month).

Earned Income Exclusion for SSI Recipients -

Allows much of a person's earned income to be excluded when figuring the SSI payment amount while a person is working.

General Income Exclusion = $20
Earned Income Exclusion = $65 and 50% of remaining income per month

Resources for SSI Recipients -

Resources can be anything a person owns, such as a bank account, stocks, real property, personal property. SSI recipients cannot have <$2,000 in savings and remain eligible for cash benefits.

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PASS Introduction

WHAT IT DOES:

A Plan for Achieving Self-Support (a PASS) allows a person with a disability to set aside income and/or resources for a specified period of time for a work goal.

WHO CAN HAVE A PLAN:

Any person who experiences a disability and who either receives or is eligible to receive SSI and has another source of income (i.e. earned income, SSDI, lottery winnings, etc.)

PLAN REQUIREMENTS:

The Plan must:

☑ be designed especially for the individual
☑ be in writing
☑ have a specific and achievable work goal
☑ have a specific time frame for reaching goal
☑ show what money and/or resources will be used to reach goal
☑ show how the PASS money will be kept identifiable from other funds
☑ be reviewed periodically by SSA to assure progress towards goal

PASS PLANNING STEPS:

1. Verify eligibility for SSI if individual is not currently receiving SSI benefits.
2. Identify and assess an achievable work goal.
3. Research all expenses necessary to reach goal.
4. Calculate feasible monthly PASS savings amount.
5. Define time frame needed to accomplish goal.
6. Put plan in writing using the list of requirements (see page 2)
7. Contact SSA to meet with either individuals representative or the Work Incentive Specialist on staff.

REQUIRED PASS ELEMENTS:

1. Claimants' name
2. Claimants' Social Security Number
3. Occupational objective
4. Month and year of PASS completion
5. List of planned expenditure(s)
6. Resources currently owned (if any)
7. Resources to allocate towards occupational goal
8. Current savings towards goal (if any)
9. Individual's/agencies assisting claimant
10. Signature of claimant
11. Date

THE OCCUPATIONAL OBJECTIVE:

This must:

- Be designed especially for the individual
- Identify the individual's proposed occupation (i.e. restaurant owner, bee keeper, file clerk, etc.)
- Be achievable and realistic given the individual's abilities
- Provide an opportunity for the individual to produce additional income leading to financial sufficiency, in part or in whole.

LIKELY PASS CANDIDATES:

☐ A person with a disability who is interested in employment.

☐ A person with a disability who is earning above Substantial Gainful Activity and/or who will see a reduction in SSI benefits due to earned income.

☐ A person who would otherwise lose their eligibility for benefits or have benefits reduced, suspended, or terminated due to excess income or resources.

☐ A person with a disability who is already receiving training or vocational rehabilitation services or is in school.

☐ A person with a disability who is currently looking for employment or who is interested in becoming self-supporting.

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UNLIKELY PASS CANDIDATES:

- ☐ A person who is ineligible for SSI for any reason other than excess resources or income.
- ☐ A person who is under age 15.
- ☐ A person who is terminally ill.

PUTTING A PASS TOGETHER

Step 1.....The Preliminaries!!

Writing a PASS involves closely examining the financial circumstances of the individual receiving benefits, the claimant. By doing this early in the process, both you and the claimant will have a better idea of what he/she can afford and how a PASS will impact his/her Social Security checks and/or work income.

The following table may be used to detail the claimant's personal financial picture:

Monthly Income:

Source:	Amount:
SSI Check	
SSDI Check	
Gross* Work Income *before taxes and deductions	
Personal Assets (Example: savings accounts, Investments, Trust Funds, etc.)	
Other:	

Obtaining information on the monthly expenses that the claimant incurs will assist you in ensuring that the individual has enough funds to cover his/her budgetary needs. This information is important in determining whether the claimant will be able to meet his/her financial obligations while working towards an occupational goal.

The following table can be used to list the claimant's monthly expenses and/or bills. If something is not listed or is paid other than monthly, use blank lines at bottom.

Monthly Expenses:

Expense:	Amount:	Due Date:
Rent/Mortgage*		
Utilities:		
electricity		
gas		
phone		
water		
Food at Home*		
Food out		
Laundry		
Bus Fare/Pass		
Gas (car)		
Medical Expenses (Doctor visits and medications, etc.)		
Personal Items		
Barber/beauty shop		
Cigarettes		
Entertainment		
Hobbies		

*If no rent or food expenses are incurred due to supported living arrangements, be sure to consider this as in-kind support for SSI calculations

Step 2........The Occupational Objective

The Social Security Red Book on Work Incentives describes the **Plan for Achieving Self-Support or PASS** as "an opportunity for people to set aside income and/or resources for a specified period for a work goal" (p 45). This work goal should be decided upon before moving on any further. The occupational objective must be designed especially for the individual and must be realistic and achievable based on the individual's abilities. This is a critical step in PASS-development as all further steps build upon this objective.

Please define the work goal of the claimant and how a PASS will help him/her to achieve this goal:

The Occupational Objective is to:

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With the Occupational Objective clearly defined the necessary expenses can now be identified. When considering expenses relative to achieving the work goal, it is important to 1) be thorough in planning expenses and 2) think in terms of the length of the PASS and then beyond. For example, if the claimant's goal was to buy a car to get himself to and from his job, it would be critical to consider the price of the car, insurance, registration fees, maintenance costs, and gas. All of these expenses can and should be part of a well-developed PASS. Alternatively, if the goal was to obtain a job working within a retail store and the individual anticipated needing assistance on-the-job, it would be important to plan for paying for a job coach as well as any uniforms or special clothing that may be needed. It is important to consider expenses necessary to reaching the goal in addition to expenses to support the maintenance of the acquisition.

Step 3........Anticipated Expenses

The next step is to outline all of the expenses that will be connected with the claimant reaching his/her work goal. An example has been provided:

Item:	Estimated Cost	Monthly or One Time Expense?	Subtotal
Books for 4 Semesters	$150.00 X 4	Fall and Spring Semesters	$600.00
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
		Total of All Expenses:	$

Step 4 - Time Frame

After all the PASS expenses have been listed and estimated, the time frame for the PASS can be calculated. It is important to note that PASSes, unlike Impairment Related Work Expenses, are time-limited work incentives. The maximum time period is 36-months unless the occupational objective is to receive education or training, in which case it can be extended to a maximum of 48-months.

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THE EQUATION: Total PASS expenses ÷ Monthly sheltered amount = Number of months required to reach goal and complete PASS

$________________	÷	$________________	=	________________
Total PASS expenses from Table in Step 2		Amount of work income or unearned income claimant is able to shelter each month for PASS		Number of months required to reach occupational goal.

At this point, it may become necessary to adjust the amount the claimant is sheltering each month if it effects his/her eligibility for SSI. This equation may be manipulated to calculate the optimal monthly PASS deposit in order to possibly increase the SSI check.

Step 5 - Putting it on paper....

All of the previous researching and planning now must be put into written form. It is critical that all of the listed elements are part of the PASS, but there is no required format.

Although not described earlier and not a required section, including a brief narrative section is sometimes helpful in explaining the claimant's occupational objective and means of achieving his/her goals. This provides the format to provide more details regarding the goal and the individual's unique needs and how the listed expenditures will help the individuals reach the work goal.

Step 6 - The Meeting....

The final step to getting a PASS initiated is submitting the written document to the Social Security Administration. This can be done by contacting the local office to inquire as to who reviews and approves Plans for Achieving Self-Support. This is generally the Claims Representatives themselves, however, some offices have a designated Work Incentive Specialist who reviews all submitted Plans. PASSes may also be mailed to the SSA, but it is beneficial to meet with the SSA Representative in person in case any additional information is needed.

Step 7 - Getting Started....

After reviewing a PASS, the SSA will send a letter indicating their decision to both the claimant and, generally, to the individual/agency assisting in the development if this was indicated. In the case of an approved plan, the letter will indicate what expenses were approved, the initiation date, the amount to be sheltered each month, the claimant's responsibilities, and the Compliance Review date, as well as the customary Appeal information.

The Social Security Administration is required to periodically review all PASS Plans. This is usually done every 6 to 8 months and is done to insure that the claimant is progressing towards the stated occupational goal. It is very important that accurate records and receipts are kept for expenditures made with PASS funds as well as bank statements for the account being used for PASS funds.

PASS EXAMPLE:

Jeff receives SSI benefits and has just recently been hired as a part-time Basketball Referee at a local gymnasium. In order to accept this position, Jeff will need to purchase 3 Officials' Uniforms, Black Court Shoes, and will need to enroll in 4 Training and Certification Classes with the City Recreation Department. Jeff has heard about the Plan for Achieving Self Support and would like to incorporate the above expenses into a PASS plan. Jeff's PASS could be written as follows:

Occupational Objective: To gain part-time employment as a Basketball Official.

Planned Expenditures:

Item:	**Month of Purchase:**	**Estimated Cost:**	**Subtotal**
3 Officials' Uniforms	Months 1 - 3	$165.00 ($55.00/ uniform)	$165.00
Black Court Shoes	Month 1	$85.00	$250.00
4 Certification Courses	Months 2 - 6	$300.00 ($75.00 per course)	$550.00
Total of All Expenditures:			$550.00

Jeff currently has no resources to contribute to his PASS expenses. However, he will be earning $4.50/hour within his new position. Jeff would like to shelter $100.00/month of his earned income into his PASS account in order to reach his identified occupational objective. He plans to open a separate savings account at his financial institution in which he will deposit his PASS funds.

Length of Jeff's PASS:

$550.00	÷	$100.00	=	5.5 Months
Total PASS expenses		Amount of work income or unearned income claimant is able to shelter each month for PASS		Number of months required to reach occupational goal.

From this equation, Jeff would have 5 1/2 months to shelter $100.00/month. This would allow him to not only purchase the items that he needs for his employment, but would also have the impact of enabling him to collect a higher SSI check than he otherwise would be able to without a PASS plan. The following table illustrates the effect of working on Jeff's SSI check with and without the PASS plan:

SSI CHECK AMOUNT WITH AND WITHOUT PASS:

	Without PASS	**With PASS**
Gross Earned Income:	$405.00	$405.00
General Exclusion:	- $20.00	- $20.00
Earned Income Exclusion:	- $65.00	- 65.00
=	$320.00	$320.00
	÷ 2	÷ 2
Countable Earned Income:	$160.00	$160.00
Less PASS Amount:	**- $0.00**	**- $100.00**
Total Countable Income:	$160.00	$60.00
1994 FBR:	$446.00	$446.00
Less Total Countable Income:	- $160.00	- $60.00
New SSI Amount:	**$286.00**	**$386.00**
Monthly Dispensable Income		
SSI Check	$286.00	$386.00
Earned Income:	$405.00	$405.00
Total:	$691.00	$791.00
- PASS Amount	-0-	- $100.00
Usable Income:	**$691.00**	**$691.00**

Thus, while Jeff has a PASS to cover for the expenses he will incur in realizing his occupational goal, he will be able to collect a higher SSI check. Because he must allocate $100.00 of his earned income towards the approved PASS expenses, Jeff's disposable income remains the same, even though he is receiving wages.

OTHER IMPORTANT PASS POINTS:

- The Social Security Administration reviews claimants' progress on their Plans generally every 6-9 months. For some individuals, it may be beneficial to request more frequent progress reviews.

- It is important to maintain communication with SSA in the event of any changes in the claimants' status (i.e. employment change or loss, increase in wages, etc.) so that overpayment can be avoided.

- It is critical for the claimant to maintain accurate records of their PASS funds. This includes receipts for items purchases, bank statements, mileage, etc.

- When it comes to developing PASS plans, be creative, and consider all of the claimant's needs, now and in the future.

- Large and long-term occupational goals can be broken down into one or two PASS plans to avoid committing the claimant to a lengthy PASS. For example, instead of writing one PASS for transportation and school expenses, prioritize the needs and goals, and complete one PASS successfully before embarking on the next need/goal.

- Maintain records of all communication with the SSA. Also, stay abreast of claimants' work and benefit status (i.e. tracking Trial Work Periods for people collecting SSDI, etc.)

- While one of the requirements for a PASS is eligibility for SSI, an individual who only collects SSDI *becomes* eligible for SSI when he or she shelters all or part of their SSDI with a PASS.

- A claimant can have multiple PASSes but can only have one at any given time. If the claimant is working, he/she can have a PASS and claim for Impairment Related Work Expenses (IRWEs).

- Some **possible** PASS expenses: tuition, books, supplies, and all other fees/costs associated with an educational or occupational training program, attendant care, child care, equipment or tools, dues and publications for academic or professional purposes, uniforms or specialized clothing, safety equipment, operational or access modifications to buildings or vehicles, medical and social services, maintenance costs and/or interest fees for any of the above items. This is not intended to be all-inclusive.

EMPLOYMENT OPTION

1906

JOB CLUB MANUAL

IMPLEMENTING THE JOB CLUB MODEL WITH PERSONS WHO HAVE A PSYCHIATRIC DISABILITY

THE REALITIES OF FINANCIAL DISINCENTIVES TO EMPLOYMENT

(see Videotape)

2 min., 50 sec.

INTRODUCTION

The job club model was originally described by Nathan Azrin in the late 1970's. Working with persons with disabilities, Dr. Azrin investigated the utility and efficacy of a structured group approach in enabling them to successfully secure positions of employment. The model has been used over the years with various consumer groups. Our interest is in its usefulness for persons with major psychiatric disabilities and for whom job acquisition and retention have been long standing and difficult to solve problems.

The small group experience can provide specific benefits to the potential job-seeker. Through the group process, consumers

(1) can develop self-reliance and experience positive feedback on their self-initiated initial and continuing efforts to find a job.

(2) The members of the group can acquire specific job readiness skills.

(3) The group provides an environment in which its members can share with their peers and benefit directly from the mutual sharing and learning that occurs.

(4) Finally, the group provides learning activities that an individual alone could not be a part of such as role playing, modeling, and group discussion.

FOSTERING SELF RELIANCE

Looking for work can be one of the most stressful activities in the life of most persons. It can be a long term endeavor with many negative experiences and few rewards and can make the most steadfast of persons feel discouraged and despair and wonder if it's at all worth the effort.

Group support can help to combat the discouragement, frustration and lowered self-esteem that many of our clients, who have a mental disorder, suffer. Participation in the Job Club enables and empowers the members to deal with the task of job seeking not as a punishing and incidental activity but as an ongoing and manageable one with specific tasks and strategies that can be defined, tried out, evaluated and revised.

. How do I cold call an employer?
. What is the best way to present myself in writing?
. What personal resources do I have?
. How do I get a job interview?

Now, let's look in on a Job Club in process. First, we'll experience how members are oriented to the group, what expectations are to be met by the members, and what can be expected from the group leader - active efforts to foster self-reliance and initiative from the outset.

50 sec.

ACQUIRING SPECIFIC JOB READINESS SKILLS

The most effective style within the job club setting is one of continuous encouragement and praise while maintaining structure and a task orientation. Didactic instruction is combined with individual assistance and guidance to the group members as needed. The group leader also promotes mutual assistance among the members.

The single, overriding objective of the group is to help each job seeker to obtain employment. The group's focus is on instructing and encouraging the members in the specific activities that will help them to obtain this objective. It has been well documented that a positive correlation exists between attendance at a Job Club and securing employment.

1 min., 15 sec.

THE USE OF EMPLOYERS

The participation of actual employers from the local community is an invaluable resource for the group's members. The benefits for members are several.

- the opportunity to ask "real-life" questions of a "real-life" person
- the employer has built-in credibility
- talking with employers provides a "dry run" for the members and can decrease the anxiety of talking with an employer without the risks associated with the real life job interview
- Consumers can ask questions that would generally never dare to ask in an actual interview.

Inclusion of employers also provides an excellent means for introducing potential employers to possible employees. The stigma which colors the employment prospects of persons who have a psychiatric disability is great. And, this initial encounter wherein the employer is the established expert can help to lessen his or her built in preconceived notions or preexisting fears about hiring persons who have a mental illness into the workforce.

25 sec.

JOB CLUB ACTIVITIES

In the process of acquiring specific job readiness skills often times the group members are able to verbalize concerns that otherwise might go unsaid, causing a great deal of stress and worry later on. The preparation of resumes, cover letters, and job application forms facilitates the acquisition of specific strategies and approaches that the consumer can learn, become comfortable with, and adapt in light of his or her own needs and values.

36 sec.

SHARING AND MUTUAL LEARNING WITH ONE'S PEERS

Generally, individuals are open to feedback and suggestions from those persons in situations similar to their own. The practical and emotional support of the group's members for each other also benefits the group's leader. Each member shares in the responsibility and burden of finding jobs for each of the members. Because of this mutual learning and sharing, leader "burnout" is prevented and the reluctance and pessimism that many professional often feel with the same task--finding jobs--and with only on ally, the individual client or consumer, can be appreciably diminished.

1 min., 30 sec.

GROUP LEARNING ACTIVITIES

The experience of participating in "mock" or simulated job interviews, which are simultaneously video-taped, is an enormously effective means to reinforce the didactic learning process and to enable the group members to become even more "active" learners.

While didactic presentations are always accompanied by group discussion, the opportunity to simulate a real-life situation and then to see oneself as an observer might see one is invaluable.

The playback may be either immediate or delayed and it is very useful to stop the tape or repeat various segments to emphasis a point or focus on an issue. This technique is particularly useful for consumers who may not be aware of their verbal or nonverbal presentation in an interview situation.

For the purpose of demonstration, you will now see an example of a "bad" interview which is designed to illustrate typical problems and ineffective response patterns which a consumer might experience or engage in. Next, a "good" interview" is demonstrated. Here the intent is to model how an individual might deal with issues such as gaps in the employment history, reasons for leaving previous jobs, and how to present oneself in the best light possible during the job interview.

1 min., 31 sec.

CONCLUSION

Well, you've just seen a Job Club in process. It's an exciting and worthwhile undertaking for any of you who are in the business of job development and placement. It is a unique approach in that the responsibility for securing jobs is a collaborative effort between the group leader and the group's members.

Also, one of the basic premises of the Job Club approach is that small groups and the group process itself can be therapeutic instruments in and of themselves.

The group provides acceptance and support for its members as new feelings of independence and responsibility emerge.

Old values and behaviors are reexamined, reevaluated, and changes if and when the individual member so desires.

Biased and unrealistic perceptions are subjected to reality testing through the group's interactions.

Feelings of self-confidence and self-worth are enhanced by the group's acceptance of each other.

These group process effects, combined with the didactic and technical expertise of the group leader, result in a highly effective and efficient means of tackling one of the most stressful and difficult tasks facing the individual disabled by virtue of a mental illness -- securing a job.

ADDENDA I

I. You have just finished viewing Part I of "Implementing the Job Club Model with Persons who have a Psychiatric Disability". Part II of this tape contains simulated job interviews which are meant to illustrate both ineffective and effective job interviewing.

II. After watching the following job interview, tell us what you think went wrong?

III. After watching this second job interview, tell us what interviewing skills the interviewee has put into practice?

OneStep®
INDEX SYSTEM

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Cardinal®

JOB CLUB AGENDA

Week 1	Orientation
Week 2	Resumes and Cover Letters
Week 3	Applications
Week 4	Interview Questions
Week 5	Continue Interview Questions; Introduce Sources for Generating Job Leads
Week 6	How to Make Effective Telephone Contacts
Week 7	Financial Incentives to Work
Week 8	Social Service (Rehabilitation) Agencies that Provide Placement Assistance
Week 9	Wrap up Evaluation

CONFIRMED EMPLOYER PRESENTATIONS

2/19/92	Richard Jozwiak - University of Pittsburgh
3/4/92	Steve Young - VA Hospital, Oakland
3/11/92	Denise Hartz - Integra Corporation
3/18/92	Jane Moyer - Xerox Corporation
4/1/92	Glenn Gorse - Internal Revenue Service

You will be given handouts that pertain to these and other topics for future use. Additionally, you will be provided with instruction and assistance in the use of the word processing program, Word Perfect 5.1, and computer time to individualize resumes and cover letters if you wish to do so. Job leads will be available after every session.

APPENDIX C: Behavioral Contract

JOB SEEKING SKILLS
LETTER OF AGREEMENT

As Group Leader, I agree to:

1. Provide instruction, lead discussion, and guide group members in the hands-on development of job seeking skills. These include:

   a. Finding and making the most of job leads.

   b. Completing employment applications.

   c. Writing a resume.

   d. Development of self-presentation skills.

2. Assist individual members during scheduled group sessions, as appropriate.

____
Group Leader signature

As Group Member, I agree to:

1. Attend the group as scheduled and on time. I will phone ahead (phone number) if I have to miss a meeting.

2. Actively participate in the group.

3. Do homework assignments.

____
Group Member signature

Date:____________

appendix 2

BACKGROUND INFORMATION FORM

1. Name ____________________ Sex ________ Age ________ Marital Status ________

2. Address ____________________ City ____________ State ____________

   Telephone number where you can be reached ____________

3. Are you enrolled in school? ________ Hours and days ____________________

   Are you a high school graduate? ____ a college graduate? ____ Major ____________

4. Are you a member of any union? ________ Name the union ____________________

5. Have you ever served in the Military? ________ Name the branch ____________

   Describe your duties ____

6. Are you currently employed? ________ Hours and days per week ____________

7. Type of job ____

8. What is the ideal job that you want? ________________________________

9. What types of jobs have you been looking for? ____________________

   ____

10. How many persons are financially dependent on you? ____________

11. What is the minimum salary that you would consider? ____________

12. How long could you manage financially before a job is essential? ____________

13. How much financial support are you receiving from the following sources:

    Part-time work ____________

    Veterans benefits ____________

    Public assistance ____________

    Unemployment compensation ____________

    Family ____________

    Other sources ____________

    Full-time work ____________

    G. I. Bill ____________

    Food Stamps ____________

    Social security ____________

    Alimony ____________

    ____

14. Name any family members who live in this area ____________________

15. Give a permanent address and telephone number of a friend or relative where you can always be reached ____

16. Do you have a car to use in job seeking? ________

—continued

17. **Can you come to a job-finding meeting every** week? ________ **Can you stay** for 2 hours? ________ If **not, please explain** ____

____

Employment History

List below the jobs you have had, starting with the most recent one.

Type of Job	Things you were responsible for
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

JOB SEARCH INFORMATION FORM

CLIENT: ______________________________

I. INTERESTS

A. First job choice: ______________________________

B. Second job choice: ______________________________

C. Comments: ______________________________

____

II. SKILLS

A. From past jobs: ______________________________

____

B. From training: ______________________________

____

C. From volunteer work: ______________________________

____

D. From hobbies: ______________________________

____

E. From education: ______________________________

____

III. APTITUDES

A. Transferrable skills: ______________________________

____

B. Established by CAPS: ______________________________

____

IV. ATTITUDES TOWARD WORK AND SUPERVISION

____

____

V. FUNCTIONAL LIMITATIONS

A. Physical: ______________________________

____

B. Emotional: ______________________________

____

C. Intellectual: ______________________________

____

VI. OTHER FACTORS (child care, transportation, etc.)

____

____

CLIENT EMPLOYMENT AND PLACEMENT TEAM

UNEMPLOYMENT ANALYSIS FORM

CLIENT NAME: ____

"WHY IS THIS CLIENT NOT WORKING?"

List those factors that may be contributing to the client's unemployment including such issues as labor market information, transportation, child care, need of direction, unrealistic goals, ineffective job search techniques, disincentives, attitude, independence, etc.

1.

2.

3.

4.

5.

6.

7.

From the above list, objectively identify the barriers and their proposed solutions.

PROBLEM	SOLUTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	

JOB SEEKING SKILLS COURSE
JOB SEARCH PLAN

Name: ____________________

Employer Name and Address	Phone Number & Contact Person	Job to Apply for	Date Contacted	Comments/Notes
	Phone Number: Contact Person: Title:		Follow-up:	Application submitted __yes __no Resume submitted __yes __no Interview scheduled __yes __no
	Phone Number: Contact Person: Title:		Follow-up:	Application submitted __yes __no Resume submitted __yes __no Interview scheduled __yes __no
	Phone Number: Contact Person: Title:		Follow-up:	Application submitted __yes __no Resume submitted __yes __no Interview scheduled __yes __no
	Phone Number: Contact Person: Title:		Follow-up:	Application submitted __yes __no Resume submitted __yes __no Interview scheduled __yes __no
	Phone Number: Contact Person: Title:		Follow-up:	Application submitted __yes __no Resume submitted __yes __no Interview scheduled __yes __no

Handout #8

Job Club Invitation Letter

^D

1~
2~
3~

Dear 4~:

Neuropsychological Assessment and Rehabilitation Services is instituting a Job Seeking Skills Group in which you may be interested.

Your N.A.R.S. clinician has suggested that I contact you to offer the opportunity to join this group. The members, like yourself, have identified their occupational objectives, but may feel the need to further develop specific job seeking skills. Such skills include resume writing, completion of employment applications, locating and utilizing job leads, and the development of self-presentation skills. The first meeting will take place on Wednesday, February 12, 1992. It will be held in Suite 606, from 1:00 p.m. to 2:30 p.m. We will meet at this time every week through April 15, 1992.

You will also have the opportunity to meet with individuals from personnel departments of local companies. Representatives from the University of Pittsburgh, Xerox Corporation, Veterans Administration Hospital, Integra Corporation and the Internal Revenue Service have already confirmed attendance and there will be other employers included.

If you are interested in participating in this group or want to find out more about it, please call 624-2842. I look forward to hearing from you.

Sincerely,

Sharon Heinlein, M.Ed., CRC
Specialty Counselor II
Neuropsychological Assessment
and Rehabilitation Services

/jd

Letter to Confirm Employer Presentation with Questions to Expect

February 24, 1992

Ms. Amy Miller
Employment Recruiter
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213

Dear Ms. Miller,

As per our conversation, I will be conducting a Job Seeking Skills Group for adults on Wednesdays from 1:00 - 2:30 p.m. and I am looking forward to your presentation for our group on Thursday, March 12, 1992. If possible, please touch upon the following topics during your discussion, as these issues seem to be of particular concern to group members.

1) Which types of positions are available with your company? Which must you recruit heavily and/or most frequently?

2) What are the minimum educational and/or experiential requirements for entry level, unskilled, semi-skilled, and skilled positions?

3) Are there any means of obtaining information regarding current open positions in addition to that available in the job posting?

4) Do you verify employment and personal references and at what point? Describe the range of responses you receive as a result of your inquiries.

5) Please explain the various job categories, such as temporary and casual, and the average length of time an individual remains in a part time position before it becomes full time.

6) If an applicant applies for a position in housekeeping, for example, and an escort position becomes available for which he/she feels qualified, is it necessary to re-apply in person or can a telephone call be made to personnel? Does another job application need to be completed?

7) When a person applies for several jobs such as housekeeper, escort or general clerical on a single application, how are these applications filed in personnel and would such a candidate actually be considered for all three of these diverse positions?

8) What makes an applicant stand out during the application and interview processes?

9) Will there be any personnel policy changes due to the passage of the Americans with Disabilities Act (ADA)?

10) What affirmative action efforts are currently in place at Western Psychiatric Institute & Clinic and will due you expect any changes with the passage of the ADA?

Any information about applying and interviewing for positions within your company which you may contribute to our group will be greatly appreciated. Please do not hesitate to contact me at 624-2842 if I may be of any assistance to you in any way.

Sincerely,

Sharon Heinlein, M.Ed., CRC
Specialty Counselor II
Neuropsychological Assessment
and Rehabilitation Services

/jd

Cover letters

1929

The Basics

There is a formula that can be followed for cover letters. I stress *can* because the most important advice I can give you about this formula and the many sample cover letters at the back of this book is: Don't be afraid to deviate from the formula. Steal phrases, words, and basic structures to your heart's content, but adapt each cover letter to the specific situation. Be a professional and write your own letters.

It's critical that your letter is unique and specific to you—not one that any applicant could have written. Employers can smell a formula a mile away, yet most job-hunters insist on writing letters that sound the same as every other cover letter. As a result, most letters are insufferably dull. You'll make the employer's day if you write an interesting letter. I've had employers call me just to compliment me on my cover letters even when, for one reason or another, they weren't able to hire me.

If you're having trouble getting started, see the worksheets on pages 15 and 17.

The Cover Letter Formula

First paragraph: Tell why you're writing, in such a way as to arouse the employer's interest. Use this paragraph to display your specific knowledge about the company you're writing to.

Second paragraph: Briefly describe your professional and/or academic qualifications. Identify the job title or general area you're interested in. The reader shouldn't have to guess what kind of job you're looking for.

Third paragraph: Relate yourself to the company. Give details as to why you should be considered. Cite examples of your qualifications for the position sought. Draw on the power of your resume and refer to it—but better yet—expand on it. Avoid trite, overused phrases, such as "as you will note in my enclosed resume" or "I have taken the liberty of enclosing my resume." If you are short on job experience, mention extracurricular activities, especially examples of leadership, special projects you worked on, or the fact that you worked your way through school. If you're a homemaker returning to the workforce, don't forget to include volunteer work and family-management skills.

Fourth paragraph: Request action. Ask for an interview appointment. Suggest a time. Tell the employer that you will call to make an appointment. **[Be sure to follow up!]** It's a lot harder for the employer to ignore a request for action than a wishy-washy "call me if you're interested" approach.

Before closing: Thank the prospective employer for his or her time and consideration.

Dear So and So: To Whom Should You Send Your Letter?

The best way to find out who should receive your letter is to call the company and ask the receptionist. For example, "Could you tell me who does the hiring for financial analyst positions?" If the receptionist refers you to the personnel department, ask also for the name of the company president. If you must choose between sending your letter to a personnel director and the company president, send it to the president (unless it's a very large company, in which case you should ask for the head of the department in which you're interested in working).

Yes, it's true the president may never see that mail. A secretary or other lower-echelon staffer will probably open and screen the president's mail, but whoever handles it is responsible for responding to the president's mail and making certain the president's image isn't damaged by failing to respond to a correspondent. The underling has to report back to the president on what action was taken; thus a chain of communication is initiated centering around your letter.

Chances are your letter will end up back in the personnel office anyway, but if you send it to the president you will increase the chances of someone with real hiring power seeing it along the way.

Attention-Grabbing Beginnings: The 20-Second Test

The biggest trick to composing a dynamic cover letter is to begin it in a way that will draw the reader in and make him want to read more—and ultimately read your resume and invite you for an interview.

Let's look at it this way: About 500 pieces of paper a week cross the desk of the average busy executive. If he or she spends 25 percent of the work day reading correspondence—and that's a very generous estimate—that means devoting one minute to each piece of paper. But many of those papers represent situations far more urgent to the executive than your cover letter, especially if it's an unsolicited one. You may have as few as 20 seconds to grab his attention.

Some ways to do that include beginning with a quote (see sample page 57), starting with a clever angle (samples, pages 58, 59, and 60), and praising the company you're writing to (sample, page 78).

Quotes

Using a meaningful quote from someone in your field can be an attention-getting way to start your letter. You should be sure that the quote is truly meaningful to the job you're seeking, and was spoken by someone your reader is likely to respect. Also, make sure your quote isn't too long. No matter how good it is, if it's too long your reader is bound to wonder when you're going to get to the point, and maybe put it down halfway through.

Praising the Employer

What employer wouldn't warm up to an applicant who talks about how much he admires the company he's applying to and how much he'd like to work there—and why? Praise for the employer is often a good approach, but you can make it infinitely more credible by supporting your praise with facts that show how much you know about the firm.

The Clever Angle

Once in awhile, you may be able to come up with an approach that is out of the ordinary and shows your creativity (see samples). If you're applying for a job in a creative field. such as journalism, advertising, art, or even sales, you can take more risks than if you're applying as an engineer, for instance. Again, be sure that what you're saying applies to the situation and isn't too long.

Pasting a Copy of the Ad to Your Letter

When responding to a want ad, you can direct your reader's attention to your reason for writing by pasting a copy of the want ad right on the letter. This is particularly effective when writing to a large company that regularly advertises openings, as the recipient can tell immediately which ad you're responding to. Seeing the ad will also refresh his or her memory about what the ad is asking for, and if you've tailored your letter well to the requirements of the ad, your reader just may end up with the impression that you're the perfect person for the job. Obviously, this is not a good approach if your qualifications don't quite match the requirements of the ad.

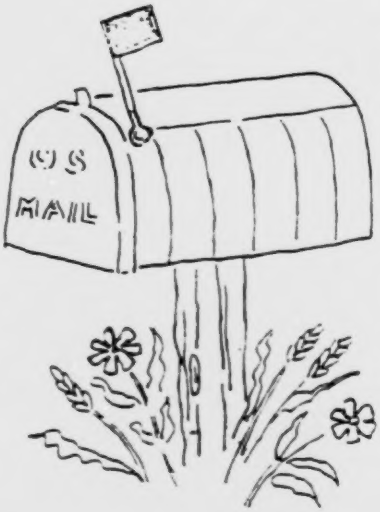
Cover Letters

Guidelines for Cover Letters:

1. ADDRESS SOMEONE IN AUTHORITY
   (who has the authority to hire you)
2. SHOW THAT YOU'VE DONE YOUR "HOMEWORK"
   (and you know about THEIR priorities and concerns).
3. CONVEY YOUR ENTHUSIASM AND COMMITMENT
4. BALANCE WARMTH AND PROFESSIONALISM
5. PRESENT SOMETHING UNIQUE ABOUT YOU
6. BE APPROPRIATE, YET STAND OUT
7. BE SPECIFIC ABOUT WHY YOU'RE WRITING
8. TAKE THE INITIATIVE ON THE NEXT STEP
9. REMAIN BRIEF AND FOCUSED

13 Sample Cover Letters:

page 270	Denise . . . Corresponding Resume, page 233
page 271	Donna . . . Corresponding Resume, page 184
page 272	Gerald . . . Corresponding Resume, page 171
page 273	Jerry . . . Corresponding Resume, page 187
page 274	John . . . Corresponding Resume, page 104
page 275	Joyce . . . Corresponding Resume, page 204
page 276	Joyce . . . Corresponding Resume, page 176
page 277	Marsha . . . Corresponding Resume, page 42
page 278	Nabil . . . Corresponding Resume, page 126
page 279	Richard . . . Corresponding Resume, page 224
page 280	Richard . . . Corresponding Resume, page 158
page 281	Teresa . . . Corresponding Resume, page 249
page 282	Cathryn . . . there's no Corresponding Resume



Want Ads Abbreviations: A Quick Language

1.	Acctg.	Accounting
2.	Advc	Advancement
3.	Aft	After
4.	Agcy	Agency
5.	Appt	Appointment
6.	Avail	Available
7.	Begnr	Beginner
8.	Bkkppg	Bookkeeping
9.	Btwn	Between
10.	Bus	Bus boy/girl
11.	Clk	Clerk
12.	Col Grad	College Graduate
13.	Comm	Commission
14.	Dept	Department
15.	Dep	Dependable
16.	Dict	Dictation
.	EOE	Equal Opportunity Employer
18.	Eqiv	Equivalent
19.	Eves	Evenings
20.	Exc,excl	Excellent
21.	Exper,Exp	Experience
22.	Exp Nec	Experience Necessary
23.	Exp Pref	Experience Preferred
24.	F/C	Full Charge(Bkkppg)
25.	F/Pd	Fee Paid
26.	Fcty	Factory
27.	Gd	Good
28.	Grad	Graduate
29.	Hrly	Hourly
30.	Hr	Hour
31.	HS	High School
32.	Immed	Immediate
33.	Info	Information
34.	Inq	Inquire
35.	Intrstg	Interesting
36.	Intvw	Interview
37.	Jr	Junior
38.	K	Thousands (in money)
39.	Loc	Location
40.	Mfg	Manufacturing
41.	Mgmt	Management
42.	Mgr	Manager
43.	Mo,M	Month
44.	Nec	Necessary
45.	Ovtm	Overtime
46.	Oppty	Opportunity
47.	Ofc	Office
48.	PDVAC	Paid Vacation
49.	Perm	Permanent
50.	P/T,PT	Part Time
51.	Pref	Preferred
52.	Req'd	Required
53.	Refs	References
54.	Rep	Representative
55.	Respon	Responsible
56.	Sal	Salary
57.	Secty	Secretary
58.	Sm.	Some
59.	St	Start
60.	Stat	Statistician
61.	Sr	Senior
62.	Vac	Vacation
63.	Vet	Veteran
64.	Wk	Week
65.	W/	With
66.	W/wo	With or Without
67.	Wkday	Weekday
68.	Wkend	Weekend
69.	WPM	Words per Minute
70.	Yr	Year

Cover Letter Vocabulary

1. Ability
2. Accuracy
3. Achieve
4. Acquired
5. Appreciate
6. Appropriate
7. Articulate
8. Asset
9. Available
10. Benefit
11. Characteristics
12. Comparable
13. Competent
14. Conscientious
15. Consideration
16. Consistence
17. Correspondence
18. Currently
19. Demonstrate
20. Desire
21. Devote
22. Diligent
23. Excel
24. Experience
25. Indicate
26. Industrious
27. Information
28. Interest
29. Opportunity
30. Persevere
31. Processes
32. Quality
33. Rapidly
34. Receptive
35. Reliable
36. Specifies

Cover Letter Phrases

1. You will find
2. I am enclosing my resume for your review
3. I am seeking a position in
4. I am interested in
5. For your consideration

. I believe my accomplishments

7. I would like to re-enter the field
8. Would like to point out
9. As my resume demonstrates
10. Welcome the opportunity to
11. Will be a pleasure
12. Thank you
13. Your earliest convenience
14. Looking forward
15. Can be reached

Complimentary Closings

1. Sincerely,
2. Very truly yours,
3. Cordially,
4. Sincerely yours,
5. Yours truly,
6. Yours sincerely,
7. Cordially yours,

NAME
STREET ADDRESS
CITY, STATE, ZIP
DATE

Dear Prospective Employer:

Please accept this letter and resume as my expressed interest in joining your organization in a capacity which will most effectively utilize my experience, skills, and potential.

I possess excellent communication skills which enable me to interface well with all levels of the general public, co-workers, and management. My background is highly diversified and I am capable and comfortable in adapting to many different situations and demands. I wish to continue learning and I would welcome opportunities to train in new areas. I work well under pressure, with or without supervision, to produce profitable results. Please note that I have a perfect attendance record in my 8 years of service at Sears, as it is my firm conviction that dedication and commitment are essential in performing one's work.

I believe I could make a valuable contribution in your behalf and would greatly appreciate the opportunity to further discuss my qualifications and you needs in greater depth.

If you wish to arrange an interview, or if you have need for any additional information, please contact me at your earliest convenience.

Thank you very much for your time and courtesy in reviewing this material and for your forthcoming response.

Sincerely,

NAME

3134 Ellers Street
Pittsburgh, Pennsylvania 15213

Angelus Convalescent Center
200 Amber Street
Pittsburgh, Pennsylvania 15206

December 3, 1982

Mr. ____________, Director of Personnel Services

Dear Mr. ________________:

I am seeking a position with your agency within the areas of housekeeping and maintenance, or as a janitor/custodian. As you can see from my resume, which is attached, I have completed a formal training program in janitorial work and have had two summers of work experience as a janitor's aide. I would appreciate very much the opportunity to prove to you that I am a hard working and dependable employee.

I could be available for an interview at your convenience and will be looking forward to hearing from you soon.

Thank you very much for your consideration.

Sincerely,

Attachment

January 29, 1990

Womens Center & Shelter
P.O. Box 9024
Pittsburgh, Pa. 15224

Dear Personnel Director:

Enclosed please find my resume for your review. I would like to be considered for the position of Community Education Specialist.

As a candidate for the job, I offer you a B.A. in Education and recent certification as a Mental Health/Mental Retardation Specialist. I have experience as a Teacher and extensive volunteer work for the Crisis Center North. I also coordinate volunteers for Circle C Group Homes for troubled youth.

I am presently unemployed as my previous job was grant funded and the funding expired. I welcome the opportunity to assist women in crisis and would like to speak with you concerning my qualifications for the job. Thank you for your consideration of my resume.

Sincerely,

James Kelley
226 Stark Avenue
Pittsburgh, PA 15206

Dear Decision Maker:

Please allow me to introduce myself. My name is James Allen Broad, and as made clear in my resume, I have a diverse background in sales, advertising, and marketing. Accordingly, I will bring with me various skills, talents, and experience to the position you presently have available.

In my present position as National Marketing Director, and over 10 years as a Regional Sales Manager, I have dealt with and mastered myriad sales situations. Coupled with my background in Counselor Education, my expertise in effectively dealing with people has been greatly enhanced.

I am confident of my ability to perform successfully in this position, and I know that granting me an interview will prove to be mutually beneficial. I will contact you within one week, to arrange an appointment. Thank you so much for your time and consideration. I look forward to our working together.

Sincerely yours,

James Kelley

November 1, 1991

Mr. Donald C. Marin
DCM Advertising and Sales Literature
119 Federal Street, 214 Martin Building
Pittsburgh, PA 15212

Dear Mr. Marin:

Enclosed, please find my resume for your review. I would like to be considered for a volunteer position with your company. If volunteer work is not feasible, I would like to have the opportunity to freelance at a minimal charge.

As you can see, I have a B.F.A. from Carnegie Mellon University and several years experience. I did not continue in this field as the freelance work was not stable employment and I needed to secure some job-related benefits; therefore I began working for the Commonwealth of Pennsylvania as a liquor store clerk.

My intentions are to eventually return to work full time in the graphic art industry. Because your agency provides design and illustration services, I would find working for you a valuable experience. Of course, I want to be an asset to your company also, as I endeavor to keep my artistic skills at a high level.

I am presently working for the University of Pittsburgh, but am not utilizing my graphic arts experience as much as I would like. My schedule allows me to be available to work in your office Fridays.

I would appreciate speaking with you, and reviewing my portfolio and qualifications. Thank you for your consideration.

Sincerely,

John T. Nagy

/jd

March 9, 1992

Manager
Software Development
P.O. 22361
Pittsburgh, PA 15222

Dear Manager:

Enclosed please find my resume for your review. I would like to be considered for a position as a VAX/VMS SAS Programmer.

As a candidate for the job, I offer you a B.S. in Information Science from the University of Pittsburgh. I have four years research experience working at Western Psychiatric Institute & Clinic (WPIC). While working at WPIC I developed particular expertise using FOCUS and Informix. I programmed and maintained the databases and produced reports as needed. Also, I gained valuable experience with statistical packages such as SAS. I am also familiar with Lotus 1-2-3, SPSS, BMDP and FORTRAN programming. My most recent position at WPIC was grant funded and the grant was not renewed. Therefore, I am presently unemployed and feel that I could be a valuable asset to your program.

I would like to speak with you concerning my qualifications. Thank you for your consideration.

Sincerely,

Mark Dewaine

Blind Box Ad Response Letter

○ Good use of Unique Selling Proposition
○ Good use of broadcasting accomplishments
○ Could have a more attention-grabbing beginning
○ Grade: A-

101 Little Patuxent
Pkwy., #278
Columbia, MD 21044
301-555-5278

Dear Sir or Madam,

This letter is in response to your ad in The Sunday New York Times.

In my present position with Mason-Dixon Accounting, Inc., I further developed my management skills as well as a strong knowledge of financial accounting. Through the use of this knowledge and experience, I was able to greatly improve the manner in which financial accounting was conducted.

By devising and applying new systems, which utilized personnel and equipment more efficiently, I significantly reduced operating costs and time spent recording routine financial transactions. The end result was a more efficient organization offering higher quality financial accounting services.

I strongly feel that my experience and enthusiasm for doing quality financial accounting would be a good addition to your organization. I look forward to your response and the opportunity to further discuss the possibility of working for your company.

Sincerely,

Patty DeRoy

Blind Box Ad Response Letter

- Applicant uses "contribution" to tell what she can do for employer
- The "30-gallon trash can" phrase was popular with employers
- Grade: A

29 Ocean Blvd.
Toms River, NJ 08753
609-555-9696

Dear Boxholder,

My strong writing background and keen interest in economic development would enable me to make a significant contribution to the public relations position you are currently advertising.

In my most recent editing positions, a 30-gallon trash can was the destination of 90 percent of the press releases I received. Based on seeing so many poorly written and mistargeted releases, I feel I could write a book or teach a course on how not to write a press release or run a publicity campaign.

I know what editors are looking for.

I know because I was most recently editor of 10 weekly papers in Ocean County. Before that, I was city editor at the newspaper in New Jersey's third-largest city. It's because of my inside knowledge of what drives editors crazy about public relations that I feel my experience is transferable to this slight shift in careers.

I'm a competent, award-winning writer and editor. One of the pieces I've won awards for is a weekly column that has dealt exclusively with social and family issues. I'm available immediately to help meet your writing and placement needs.

I can make myself available for an interview at your convenience and may be reached during business hours at 201-555-9528.

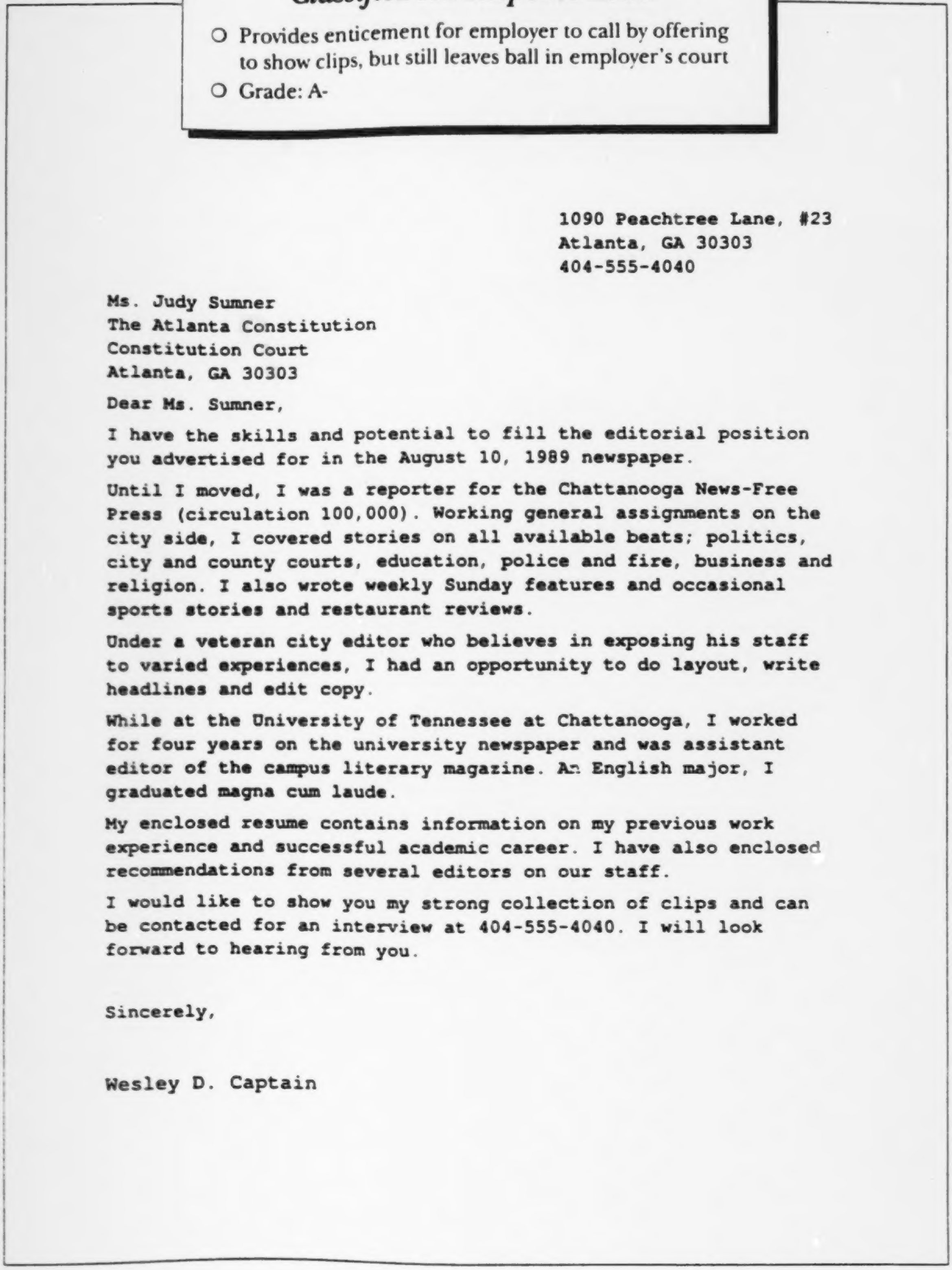
Thanking you most kindly for your consideration, I look forward to meeting with you soon.

Cordially,

Deirdre Cosgrove

Classified Ad Response Letter

- ○ Provides enticement for employer to call by offering to show clips, but still leaves ball in employer's court
- ○ Grade: A-



1090 Peachtree Lane, #23
Atlanta, GA 30303
404-555-4040

Ms. Judy Sumner
The Atlanta Constitution
Constitution Court
Atlanta, GA 30303

Dear Ms. Sumner,

I have the skills and potential to fill the editorial position you advertised for in the August 10, 1989 newspaper.

Until I moved, I was a reporter for the Chattanooga News-Free Press (circulation 100,000). Working general assignments on the city side, I covered stories on all available beats; politics, city and county courts, education, police and fire, business and religion. I also wrote weekly Sunday features and occasional sports stories and restaurant reviews.

Under a veteran city editor who believes in exposing his staff to varied experiences, I had an opportunity to do layout, write headlines and edit copy.

While at the University of Tennessee at Chattanooga, I worked for four years on the university newspaper and was assistant editor of the campus literary magazine. An English major, I graduated magna cum laude.

My enclosed resume contains information on my previous work experience and successful academic career. I have also enclosed recommendations from several editors on our staff.

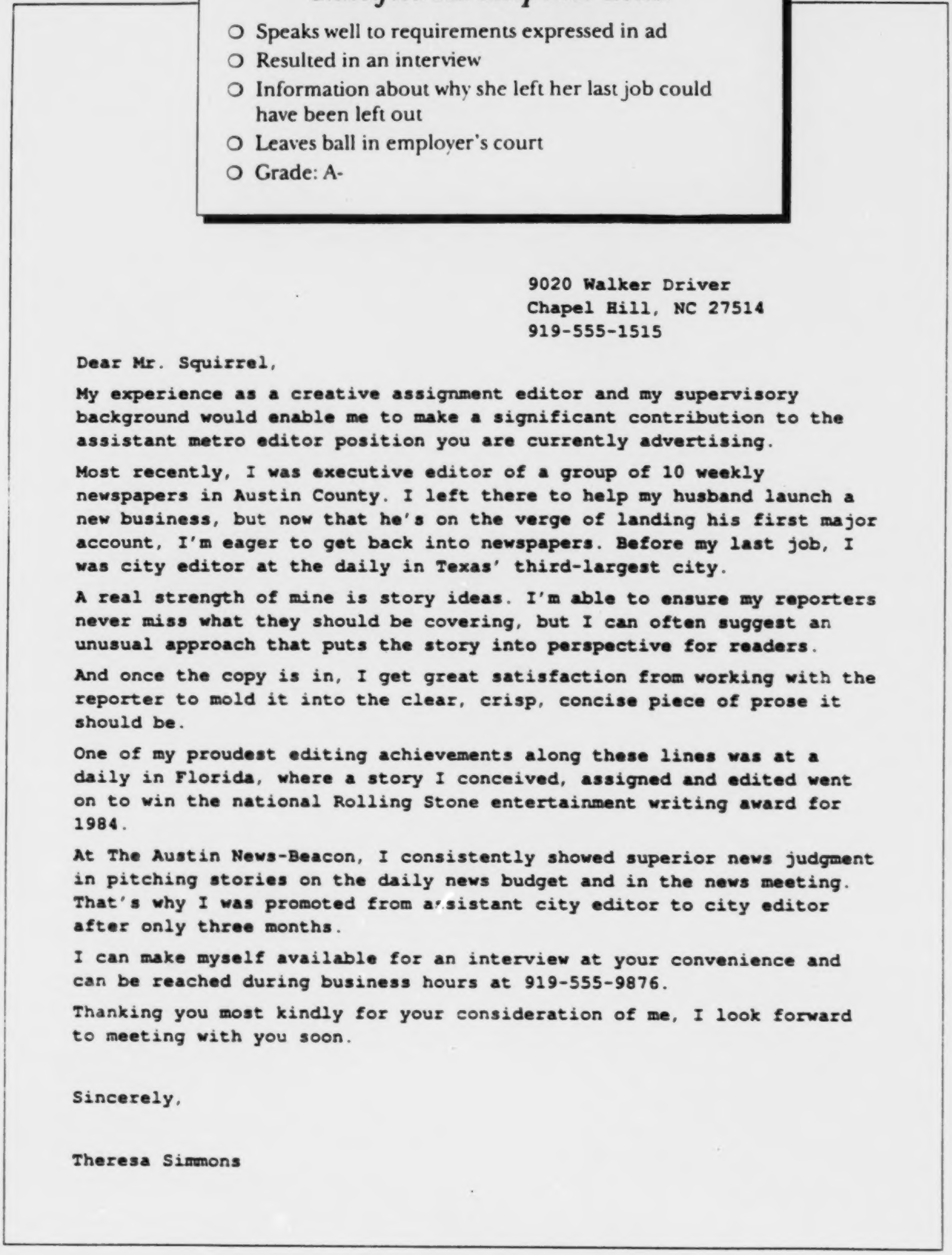
I would like to show you my strong collection of clips and can be contacted for an interview at 404-555-4040. I will look forward to hearing from you.

Sincerely,

Wesley D. Captain

Classified Ad Response Letter

- ○ Speaks well to requirements expressed in ad
- ○ Resulted in an interview
- ○ Information about why she left her last job could have been left out
- ○ Leaves ball in employer's court
- ○ Grade: A-



9020 Walker Driver
Chapel Hill, NC 27514
919-555-1515

Dear Mr. Squirrel,

My experience as a creative assignment editor and my supervisory background would enable me to make a significant contribution to the assistant metro editor position you are currently advertising.

Most recently, I was executive editor of a group of 10 weekly newspapers in Austin County. I left there to help my husband launch a new business, but now that he's on the verge of landing his first major account, I'm eager to get back into newspapers. Before my last job, I was city editor at the daily in Texas' third-largest city.

A real strength of mine is story ideas. I'm able to ensure my reporters never miss what they should be covering, but I can often suggest an unusual approach that puts the story into perspective for readers.

And once the copy is in, I get great satisfaction from working with the reporter to mold it into the clear, crisp, concise piece of prose it should be.

One of my proudest editing achievements along these lines was at a daily in Florida, where a story I conceived, assigned and edited went on to win the national Rolling Stone entertainment writing award for 1984.

At The Austin News-Beacon, I consistently showed superior news judgment in pitching stories on the daily news budget and in the news meeting. That's why I was promoted from assistant city editor to city editor after only three months.

I can make myself available for an interview at your convenience and can be reached during business hours at 919-555-9876.

Thanking you most kindly for your consideration of me, I look forward to meeting with you soon.

Sincerely,

Theresa Simmons

Classified Ad Response Letter

○ Good letter; a little long
○ Should take proactive stance with interview request
○ Grade: A-

110 Ocean Blvd.
Los Angeles, CA 90005
213-555-5678

Dear Dr. Davis,

The most important criteria in a professor are professional experience, teaching ability, and research potential. With my marketing and management experience as well as my college teaching experience, I would like to be considered for a position as one of your entry-level assistant professors. I feel confident that I am strongly qualified—and—I would love to teach any and all of the courses you mentioned in your ad in the Marketing News.

I would bring the strength of several years in the marketing field, a BS in marketing from Syracuse University and an MBA with a concentration in marketing from New York University, as well as the years of experience teaching both large and small classes.

I am especially strong in marketing research—both qualitative and quantitative, and am well versed in all aspects of promotion, advertising, consumer behavior, and marketing and business management.

My teaching skills are excellent. I am always evaluated highly by my students and department heads. I enjoy the interaction with students and am comfortable with both large lecture classes as well as smaller groups.

Please look over the enclosed resume and list of courses I have taught, and I believe you will find a strong candidate for the position.

I look forward to hearing from you in the near future. Please call me if there is anything else you might need, or if you have any questions. Enclosed, as the ad requested, you will find my vita, listing of courses taught, and the names of three references.

Thank you for your valuable time and consideration.

Sincerely,

Peter Kiser

Classified Ad Response Letter

○ Shows knowledge of and gives praise to employer
○ Leaves ball in employer's court
○ This letter resulted in an interview and job offer
○ Grade: A-

10 Redwood Forest Lane
Sacramento, CA 95841
916-555-1010

Mr. Jeff Green
The Health Center
45 Medical Court
Sacramento, CA 95841

Dear Jeff Green,

My strong writing background and intense interest in health care would enable me to make a significant contribution to the media information director position you are currently advertising.

I'm a competent, award-winning writer and editor. One of the pieces I've won awards for is a weekly column that has dealt exclusively with social, family and health issues. I have enclosed writing samples that show my commitment to health care issues.

I'm available immediately to help meet your writing and placement needs. I have good contacts in the media.

My respect and admiration for The Health Center goes a back a long way. I came to you for my health-care needs as a teenager, and I have relied on you for care and information ever since. I am truly committed to your mission.

I can make myself available for an interview at your convenience. Thanking you most kindly for your consideration, I look forward to meeting with you soon.

Cordially,

Debbie Bayne

Cold Contact Letter

- Does a good job of telling what the applicant can do for the company
- Good highlighting
- Drops the ball by not taking proactive approach to interview
- Grade: A-

85 W. 78th Street
New York, NY 10023
212-555-1010

Ms. Vanessa Graham
City Medical Supplies
23 Houston Street
New York, NY 10005

Dear Ms. Graham,

In my four years as sales manager of a leading medical supplies distributor in Westchester County, I directed the sales and marketing policies of the company's line of medical supplies and accessories.

During that time:

- Annual billings more than tripled from $3.25 million to $10.75 million.
- Profits rose five-fold, from $150,000 in 1984 to $785,000 for the fiscal year ending September, 1988.
- Number of accounts within same geographical territory increased by more than 250%.

The success I've had here and elsewhere in 12 years of selling is not a coincidence, or attributable to luck or magic. My sales success is due in part to my education in Business Administration (Harvard, 1976) and a natural ability to analyze a marketing/selling situation and come up with an innovative program that leaves the competition way behind.

What I have done for my previous employers, I am confident I can do for you.

I would be glad to make myself available for a personal interview where we can discuss how I can serve your company in increasing sales and market share.

Sincerely yours,

Thomas Mahoney

Cold Contact Letter

- ○ Good use of "what I can do for the company"
- ○ The only things that could make this letter better are a little pizazz and more specific reference to the company
- ○ Grade: A

209F N.W. 111th Street
Gainesville, FL 32609
904-555-5665

Mr. David Heller
N.J. Research, Inc.
34 Consultants Court
Princeton, NJ 08540

Dear Mr. Heller,

As marketing research companies are increasingly called upon to supply information on magazine readership to publishers, there is a growing need for trained and experienced professionals in the field.

Through my marketing/research experience and my master's thesis, which have particularly dealt with improving marketing readership studies so they can better define magazine audiences to potential advertisers, I am certain I could give you valuable assistance in satisfying research demands and improving the marketing tools you currently use.

I will be completing my master's degree in December and would be interested in making a contribution to N.J. Research's profitability in a marketing/research capacity.

I believe my services would be useful to you, and I will call you in late September to discuss an interview. Thank you for your time and consideration.

Sincerely,

Scott Morris

Cold Contact Letter

- ○ Good trumpeting of accomplishments
- ○ Good, proactive approach to interview
- ○ A little long
- ○ Grade: A-

19 Berkley Street
Maplewood, NJ 07040
201-555-1212

Dr. Julius Kane
Syracuse Law Partners
50 Comstock Blvd.
Syracuse, NY 13215

Dear Dr. Kane,

My recent experience as director of public information at an All National Law Clinic and my commitment to legal issues would enable me to make a significant contribution in a public relations/public affairs/community relations capacity. I will be relocating to Syracuse within a year because my husband has just accepted an offer to teach at Syracuse University.

Among the highlights of my tenure at All Nation has been the launch of a new clinic site. I developed a very successful marketing plan within tight budget restrictions, and as a result, the new clinic is not only building its caseload with each passing week, but we have also generated excellent awareness and enthusiasm for our services.

When I leave All Nation next year, I will have three newsletters and two annual reports under my belt. The publications I've produced thus far have been extremely well received.

I've also developed an aggressive program of regular press releases, having learned a great deal about how to get releases into print from my years as an editor. I have an excellent record of getting releases placed in local publications.

I will relocate to Syracuse no later than August, 1990, but I could relocate sooner should you have an appropriate opening. I would be willing to fly up for an interview at virtually any time, and it is likely I will be in Upstate New York around Christmastime. I will call you then to see if we can set up an exploratory interview even if you have no openings.

Should you wish to reach me to set up an interview, you may leave a message at 201-555-1212, or call that number after business hours or call me at All Nation at 201-555-9999. I'm sure my executive director would give me a fine recommendation, however, he doesn't know I'm leaving yet, so I would appreciate your discretion.

Cordially,

Joan E. Dreskin

1949

Cold Contact Letter

- ○ Quantifies accomplishments
- ○ Does an excellent job of telling what he can do for the company and its profitability
- ○ Loses impact with passive closing
- ○ Grade: A-

RR Box 12
Waverly, VT 05492
802-555-5555

Dear Mr. Black,

More than three years ago, I left the Philadelphia area to receive a working education in media and media sales. My resume indicates that I have not only learned my business from a variety of angles, but also quickly progressed to a position of responsibility in every company.

Each promotion was based on my aggressiveness and a well-proven ability to make money. I can now do the same for your company.

In my most recent position, I took a department that was already 6% behind established goals. Within a six month period, I had completely reversed that figure—plus.

The enclosed resume only partially reveals my qualities as an advertising executive and idea man. I am experienced in many facets of marketing, budget and profit planning. I have much experience in general management planning and have proven quite capable of turning a disorganized and unprofitable crew into a well-run and money-making machine.

I am currently planning to return to the Philadelphia area to put my experience to work. After two harsh Vermont winters, I am ready to return to my old stomping grounds as soon as possible.

I hope to hear from you shortly and would be happy to travel to your area anytime for an interview. Thank you for your consideration of me.

Sincerely,

John Smith

1950

Recent Grad Letter

- Transforms a possible negative, his inexperience, into a big positive
- Takes proactive approach to requesting interview
- This letter resulted in an interview and job offer
- Grade: A

7 Apple Court
Eugene, OR 97401
503-555-0303

Mr. Archie Weatherby
California Investments Unlimited, Inc.
25 Sacramento Street
San Francisco, CA 94102

Dear Mr. Weatherby,

Please consider this letter as an initial application for a position as an insurance broker for California Investments Unlimited, Inc.

I recently graduated from the University of Oregon with a degree in business, where I was president of the Future Business Leaders of America.

Although a recent graduate, I am not a typical new graduate. I attended school in Michigan, Arizona and Oregon. And I've put myself through these schools by working at such jobs as radio advertising sales and bartending, both of which enhanced my formal education. I have the maturity and ability to embark on a career in insurance brokering, and I'd like to do this in California, the state I grew up in.

I will be in California at the end of this month and I'd like very much to talk with you. I will follow up this letter with a phone call to see if I can arrange a time to meet with you.

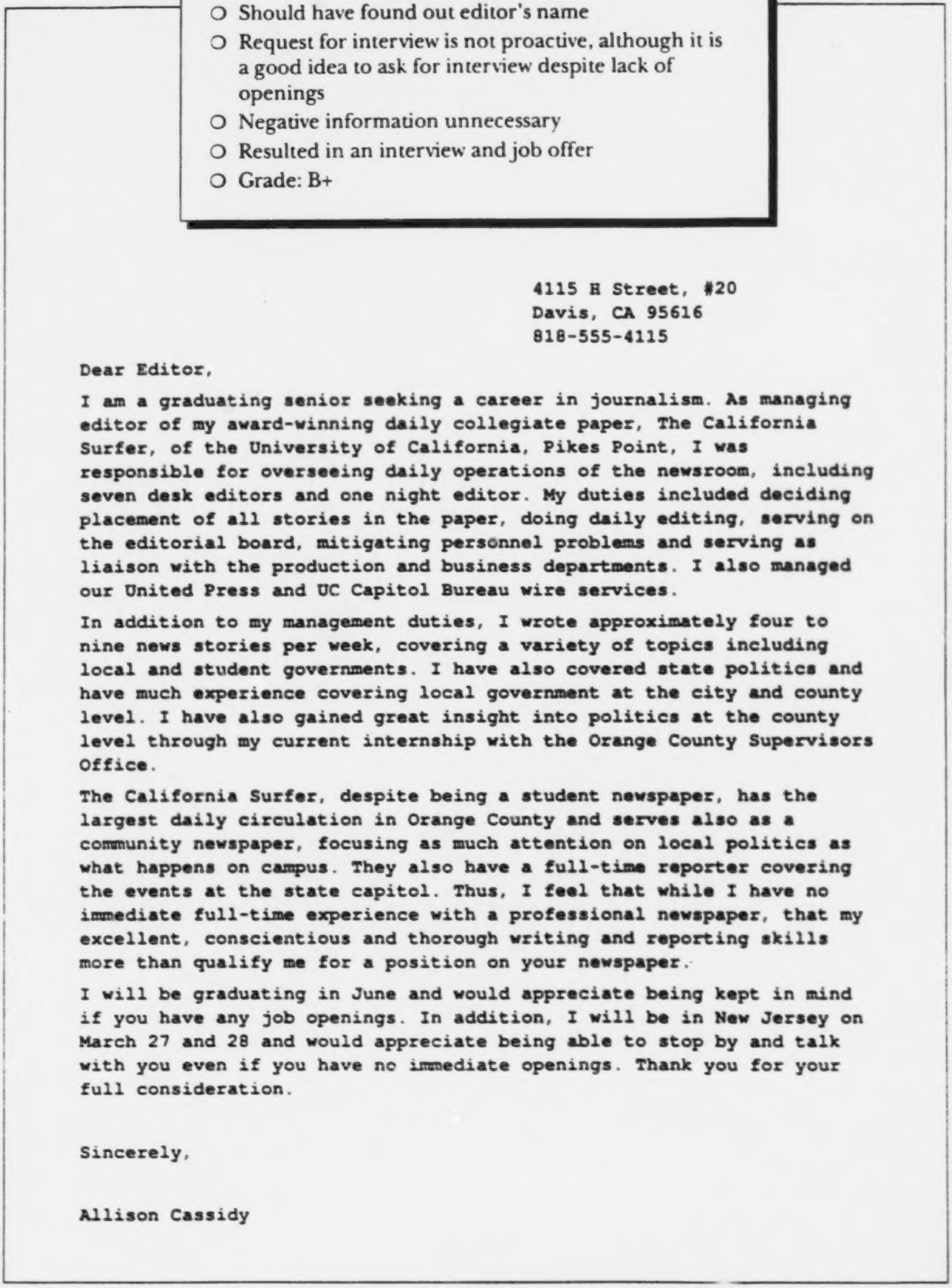
Thank you for your consideration.

Sincerely,

John Oakley

Recent Grad Letter

- ○ Should have found out editor's name
- ○ Request for interview is not proactive, although it is a good idea to ask for interview despite lack of openings
- ○ Negative information unnecessary
- ○ Resulted in an interview and job offer
- ○ Grade: B+



4115 H Street, #20
Davis, CA 95616
818-555-4115

Dear Editor,

I am a graduating senior seeking a career in journalism. As managing editor of my award-winning daily collegiate paper, The California Surfer, of the University of California, Pikes Point, I was responsible for overseeing daily operations of the newsroom, including seven desk editors and one night editor. My duties included deciding placement of all stories in the paper, doing daily editing, serving on the editorial board, mitigating personnel problems and serving as liaison with the production and business departments. I also managed our United Press and UC Capitol Bureau wire services.

In addition to my management duties, I wrote approximately four to nine news stories per week, covering a variety of topics including local and student governments. I have also covered state politics and have much experience covering local government at the city and county level. I have also gained great insight into politics at the county level through my current internship with the Orange County Supervisors Office.

The California Surfer, despite being a student newspaper, has the largest daily circulation in Orange County and serves also as a community newspaper, focusing as much attention on local politics as what happens on campus. They also have a full-time reporter covering the events at the state capitol. Thus, I feel that while I have no immediate full-time experience with a professional newspaper, that my excellent, conscientious and thorough writing and reporting skills more than qualify me for a position on your newspaper.

I will be graduating in June and would appreciate being kept in mind if you have any job openings. In addition, I will be in New Jersey on March 27 and 28 and would appreciate being able to stop by and talk with you even if you have no immediate openings. Thank you for your full consideration.

Sincerely,

Allison Cassidy

Richard's draft letter to send to various law firms.

Richard T. Griffon Jr.
5700 Riverview Street
Albany CA 94706
(415) 389-4111

Office Manager
Law Firm

Dear Manager,

After talking with a friend who is a lawyer, I was encouraged to seek work as a legal assistant, a position that has interested me for some time. My purpose in writing is to determine whether a legal assistant position is available or may become available with your firm soon.

As my resume illustrates, I have extensive experience and skills that are relevant to this position. I would very much appreciate the chance to come in and talk with you further about your personnel needs either now or in the near future.

As a professional creative writer, I'm interested in finding a job that calls for the writing and editing skills I've developed. I look forward to hearing from you soon.

Sincerely,

Richard Griffon

RICHARD JENNINGS
8009 Mountain Blvd.
Oakland CA 94602
(415) 111-6887

James Lawler
Director of Operations, Alameda County
Bay Medical Services
780 San Joaquin Street
Oakland CA 94604

Dear Mr. Lawler,

I was very pleased to learn of the opening for the Alameda County Field Supervisor-Operations position.

In my 18 months as a paramedic with Bay Medical Services I believe I have demonstrated independence and initiative in developing plans to resolve problems I encountered on the job.

I enjoy participating in the operational functions of BMS as a Crew Chief and Relief Field Supervisor.

I look forward to an opportunity to take on more responsibility in this organization and I see the position as a chance to further contribute to the development of paramedicine and to Bay Medical Services as an organization.

I have enclosed a copy of my resume and would like an opportunity to interview for this position.

Sincerely,

Richard Jennings

Resumes

1955

BASIC RESUME

- Well-suited to unskilled or semi-skilled workers, blue collar workers, skilled manual craftsman. Those who enjoy physical exertion, like to follow instructions, enjoy the outdoors, possess manual and finger dexterity, mechanically inclined.

- Simple type, elementary in its presentation.

- Helpful to those who don't think they need a resume.

- Record of past work experience including part-time or summer work, work as a trainee, under an on-the-job training program.

- Includes details of education with dates.

- Notes skills developed in volunteer work, in leisure time activities or hobbies.

- Is a curriculum vitae, a way to present information about the applicant in a graphic, well-organized manner.

Inventory - to do in preparation for writing basic resume

1. Name and Address
2. Work Record
   List your former positions and give as much information as possible about each one and length of experience. Put all information in writing; later you can extract pertinent sections.
3. Employment You Are Trying to Secure
   List the kind of work you are willing to accept and for which you consider yourself better qualified.
4. Willing to Relocate
   You should mention whether or not you are willing to relocate.
5. Service
   If you have any military background and if there is any match between that work and the job you are seeking, mention it.

You could divide your information under the following headings:
(1) Name and address.
(2) Kind of position wanted.
(3) Personal data: date of birth, condition of health, height, weight, marital status, number of children if any, willingness to relocate, etc.
(4) Work experience: what kind of work you have done up to the present, and what relation it has to the job you want.
(5) Training: what kind of schooling you have had. Did you learn your trade by means of an on-the-job program, or did you learn it through serving an apprenticeship?
(6) Of what organizations, societies or unions are you a member?
(7) State if your salary is open to negotiation or, if you are a union man or woman, whether it is in accord with union requirements. Also, if you are willing to relocate, you might bring up the

CHRONOLOGICAL RESUME

- Presents information in somewhat more detailed form than the basic resume.

- Favored by office workers, white collar assistants, sales personnel and service employees.

- May also be used by skilled craftsmen and semi-skilled blue collar workers.

- Records information in chronological order. Offers best opportunity to present details of experience exactly as they occurred without explanations.

- Arranged in reverse chronological order.

- Easy to prepare.

- Good for continuous work record showing growth and development.

- Most familiar to employers.

Inventory - to do in preparation for writing resume.

1. Name and Address
2. Work Record
   List your former positions and give as much information as possible and length of experience. You can extract pertinent material later. Do not fool yourself. Don't mention work because it sounds interesting; unless it is an activity you want to explore and for which you have the proper educational background and aptitude.
3. Educational Background
   List training, institutions where you have studied and dates.
4. Service
   If you have served in the armed forces, mention it.

You could arrange your resume in this manner:

(1) Name and address.

(2) Work record: Start each entry with the number of years you were on the job, the title of the position, if any, and the names and addresses of the companies. If you have any particular accomplishments that relate to the jobs held, then describe them as best you can to supplement the entry.

(3) Give the kind of training and experience you acquired, and above all try to emphasize the type of work you prefer.

(4) Refer to your memberships in the community and in the trade, and to whether you are a union man.

(5) References available on request.

FUNCTIONAL RESUME

A functional resume is organized according to the functions of a job. It is a good advertisement for yourself and an acceptable and ethical document to promote employment in a line of work which will bring you self-fulfillment. Not writing a functional resume is conning yourself into believing you are not as important as the employer.

A first-rate functional resume, a product of three weeks' work and four drafts disciplines people to focus on answers to three questions everyone needs to know: (1) Who am I? (2) What do I do well? (3) What do I want? Developing a functional resume helps you answer these questions.

Employers can be turned off so you do take a risk. Chronological resumes leave neutral feelings and do not turn people on or off.

It is especially suited to those who can express themselves effectively, who are interested in ideas and who are inclined to creative or artistic activity. It shows to better advantage the person who has gaps in work history or is changing careers or has never worked.

Occupational Inventory- to do in preparation for writing functional resume

1. Name and Address
2. Occupational Objectives
   This should be a clearly worded statement of the field in which you want to work. It is most important that you express yourself exactly here; you might find yourself in a position which, although it fits your qualifications, does not satisfy your ability completely or points you in the wrong direction. This statement should also tell the reader that you are not looking for just anything that might come along, so as to prevent your being offered just anything. Your overall objective may be stated generally, but the specific points in which you are interested must be stated precisely.

3. Summary of Functions- Could call it "Related Skills".

Take a sheet of paper and make a list of accomplishments - positive activities that gave you a sense of fulfillment. Go back as far as memory allows and list every accomplishment, achievement, contribution which made you feel proud deep down in your tummy - no matter how modest. Write down every job you held unless you hated it, all projects you enjoyed, all roles you've played - sister, Brownie leader, club treasurer.

Study each one and give it a name - management, mediation, planning. This will clarify your skill areas. This usually takes about 3 days!

Establish two five skill areas. Discard those accomplishments under each skill area which do not support what you want to do.

Now you have the guts of a functional resume.

You will begin to discover that many functions of your future job were performed in various forms throughout your working experience. For example, you may have kept records on one job, or checked general entries on another, or worked as an assistant in the accounting department on a third. Experience in record-keeping can be very useful in accounting. In a functional resume, this "hidden" accounting experience comes to light, and shows up more clearly than it would in a different form of resume.

On the other hand, you may be just out of school, with your experience limited to part-time or summer work. A functional resume may make you, a young trainee seeking a beginning job, appear as if you regard yourself a $25,000-a-year executive.

The volunteer work you did and what you learned in other areas of living rate equal billing with paid employment. Thus, your stint as regional convention manager for a national organization would not, in the functional resume, be buried under some routine heading such as "community activities." You can review and relate what you actually did in you volunteer role, from site surveys to bargaining, to staffing, to housing, to publicizing - right down to your final report. Depending on the job you are aiming at, you can play up the most relevant functions. For a department store, where women take charge of the fashion shows, you would emphasize your success in bringing disparate and sometimes temperamental groups together on schedule. Or if you proposed and undertook several seminars for a university, you would want to point up the financial success of what you did.

If you are writing a resume for an advertising manager, for example, you can divide your experience as follows: (a) in copy writing, describe the kinds of copy you wrote and the particular products or media for which you wrote; (b) in administration, describe its scope, and whether your experience as administrator was gained in the advertising department of some company or for some advertising agency; (c) in art, indicate the type of art work you have done, and whether you worked under supervision or independently; (d) in sales promotion, specify who employed you in that capacity.

Employment History - Could call it Work Record, Experience Record, or Employers

For each job - part-time, volunteer, vocational and full-time - write brief descriptions illustrating effectiveness for the job you want, what you've done.

Education

Detailed information about your education is useful and important. Begin with your most advanced degree. If you have a master's, name the type of degree, school, its address, the year, your major subject and any pertinent facts connected with your attaining the degree, especially the titles and publication dates of your theses or dissertations, if any. Include special training courses, special conferences if they support the job you want.

Professional Affiliations

Information about memberships in professional societies, including college fraternities, should be presented here. State any special function, duty, title, or administrative post you may hold (or have held), and whether you are an active, honorary, professional or nonprofessional member.

Outside Activities

This should include the names of all political, social, church, civic and community organizations in which you have participated actively. This information also tells the employment or personnel manager something about you in addition to your work history.

Military/Volunteer Service

Convert the terminology into understandable non-jargon that laymen can read. Keep the facts believable. If you taught English as a second language, say something about techniques used, how many taught, and skills necessary to do the job.

Willing to Relocate

References Available on Request

MODERN ANALYTICAL RESUME

The modern analytical resume is somewhat more complex than the functional resume because it presents the necessary information in greater detail. It can be said that the modern analytical resume offers the prospective employer or the interviewer a broader base from which to judge the qualifications of the applicant. It is favored by professionals, executives or highly specialized workers. For those who possess leadership qualities and can supervise others, who enjoy thinking about and solving problems, who like educational work and who are adept at figures, the modern analytical resume should be their choice.

In preparing the final draft of your resume, it is n't necessary to use every item that follows. You can select those which apply to you particularly. For example, you may know a foreign language - a valuable asset in your field of endeavor. Or, conversely, you might not want to say anything about your clerical ability, thinking that there is no need for it in your field. The instructions given here are intended to provide all possible entries for your personal resume.

The modern analytical resume is a combination of the better or more outstanding qualities of the three preceding types of resumes. It includes all the advantages of what used to be known as the Harvard Resume; that is, it analyzes, step by step, the more essential aspects of your business profile.

The modern analytical resume permits you to stress the major areas of skill that are pertinent aspects of your work, as these relate to the position you are seeking. It supplies the employer with a great many details that would not be necessary to point out in jobs that can be covered in a basic, chronological or functional resume. Also, it presents the material in more logical sequence than in the functional resume and highlights the importance of each job held in each company.

In the modern analytical resume you are given the opportunity to emphasize the qualifications for the job you are aiming at, as well as to highlight your particular skills and abilities. In addition, the modern analytical resume allows you to concentrate on the kinds of work you did and the jobs you held in the past.

For example, an engineer can arrange his modern analytical resume according to jobs worked on, presenting each as a project in problem-and-solution form. This type of resume also permits the applicant to indicate and comment on the growth achieved with each job experience. It presents ascending steps and the progress made, as reflected in the different jobs held or duties performed. Because the modern analytical resume is so very comprehensive, it offers the applicant an opportunity to submit supplemental information in a letter accompanying the resume. Needless to say, personality, character and potential ability are revealed in these, and very often they play a major role in the best outcome for the applicant.

Apart from the advantages indicated above, the modern analytical resume is particularly suited for a college graduate who has become a corporate lawyer, president of a company, marketing executive or any other post that can be classified as in the top management level.

So comprehensive is the modern analytical resume in the opportunity it offers for occupational and self-revelation, that it also provides scope for answering questions that the interviewer may ask.

In preparing your modern analytical resume, try to be as complete as possible in the information you present. It will serve you best if you do this.

Inventory

1. Name and Address

Place your name and address on one side and your telephone number on the other.

2. Summary of Experience

In 50 to 100 words summarize all the experience you have gained in the different positions you have held up to the present. This summary will provide the reader with an almost immediate idea as to whether you are the person to fill the job.

3. Occupational Objective

In a sentence or two, name your field of specialization, or fields related to it, and the position you prefer. For example, an occupational objective might be "to be associated with a growing, internationally oriented firm in the field of marketing or investment."

4. Experience Highlights

Your previous experience may be the determining factor as to whether or not you are hired.

Give the name and location of the company (or companies) you were with, the title of your position there, the length of employment. Describe your duties, pointing out those aspects of the work that might fit in with the job you now seek. If you are looking for a job in public relations or personnel, for example, you might explain your former jobs. If you are applying for a position as export manager, explain your sales experience and how it has helped you in the ability to deal with customers, to talk on the telephone, to write letters and to use the general principles of sales psychology.

5. Education

Give the details of your education and training, from high school on - the name and location of each school, the dates of your attendance and the dates of your graduation. Include the name of your curriculum or program, and the titles of any courses that had special relevance to the work you now seek.

6. Early Background

Employers generally want this information because it rounds out the picture of the whole person. Here you can tell something of your history as a child: the environmental and educational factors, including after-school activities or occupations that helped to form the adult you now are.

7. Professional Affiliations and Licenses You Hold

Information about memberships in professional societies should be presented here. State any special functions, duties, titles or administrative posts you have held or hold, and whether you are an active, honorary, professional or nonprofessional member.

If you work in a field that requires licensing from local, state or federal authorities, state those you have.

8. Personal Recognition

State the titles, publishers and dates of printing of all articles, papers, theses or books you have written. Employers like to have what is called "literary visibility" about their employees. Provide similar information in the scientific, technical or political fields.

9. Clubs and Fraternities

This should include the names of all political, social, church, civic and community organizations in which you participate actively. This information also tells the employer or personnel recruiter something about you apart from your work history.

10. Knowledge of Foreign Languages

Many companies, with their interests abroad through exports, foreigh investments and overseas branches, have an increasing demand for employees who speak another language fluently. List the language (s) you can speak fluently, but do not assume that any high school or college courses in a language can be regarded as giving you fluency. You either know a language fluently or you do not. Personnel people will almost certainly have you take a test in the foreign language. Failure in this test can be held against you.

11. Outside Activities

One young lady, interviewed for a secretarial position, was puzzled when asked if she collected coins or stamps. What could the question possibly have to do with her skills and competence as a secretary? Actually, it might reveal more about her interests and background than a series of more routine questions. An interest in stamps shows that a person enjoys handling small details. AN active pursuit of such a hobby can sharpen a person's sensitivity to fine distinctions and subtleties of arrangement.

Obviously we don't all want to be philatelists or numismatists. But it's important not to overlook the value of hobbies and extracurricular activities in selling yourself to a potential employer. The books and magazines you read, the games you enjoy and the things you collect can all be positive comments on your character and personality. An employer who knows that you participate in extracurricular activities, welfare-organization work or community projects knows that you are willing to work to accomplish things even when it is not required of you or when there is no financial reward. If you have been chairman of a committee, president of your class or captain of an athletic team, you have had practice in leadership that will make you a better candidate for an executive position. If you were advertising manager of your school paper or yearbook, the experience may prove valuable when you look for a job in public relations.

12. Willingness or not to relocate.

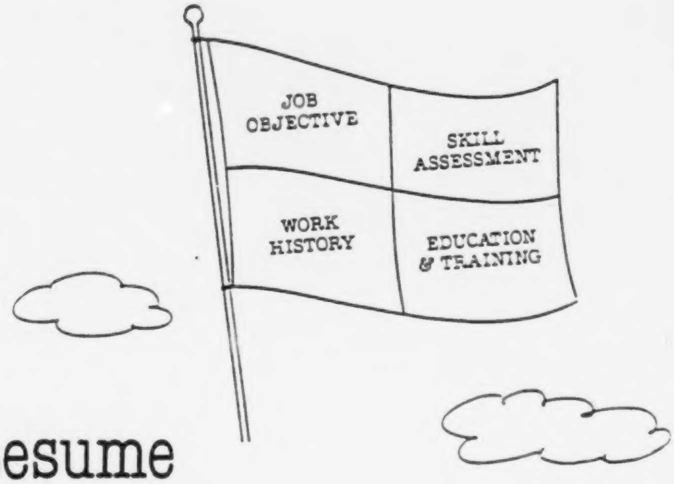
What is a Damn Good Resume?

A DAMN GOOD RESUME is a functional resume with a chronological job history. It starts with a clearly stated Job Objective, and then presents an assessment of your skills and experience in terms of that current objective. It is brief, focused, and effective.

In contrast, the old style "standard resume" listed, in chronological order, your job experiences, and the basic duties you performed under each job title. It usually omitted mention of your objective (incredible!). And worst of all, it was left to the potential employer to figure out what all that MEANT to her, what you wanted, how well suited you were for the position available.

A DAMN GOOD RESUME is designed to give you full credit for what you've learned and accomplished, regardless of where or when, regardless of job titles or pay.

And it's a refreshing RELIEF to the employer; she looks it over and sighs, "WOW, finally somebody who knows just what she wants, knows what she has to offer, and even seems to know what WE need too!"



A Damn Good Resume Has Four Basic Parts

- * A clearly stated JOB OBJECTIVE
- * A SKILL ASSESSMENT related directly to the Job Objective
- * A listing of your WORK HISTORY
- * A listing of your EDUCATION & TRAINING

A DAMN GOOD RESUME DOES NOT HAVE:

Personal information that's irrelevant to the job — age, marital status, height and weight, hobbies.
Vague references to a job objective — like "I want to work with people."
Jargon — like "interface."
A clutter of too-precise dates — we simply say "1971-1975."

HERE'S WHAT A DAMN GOOD RESUME CAN DO:

Focus attention on your strong points.
Minimize the impact of times when you were unemployed.
Demonstrate that you're a "pro" even if you've never been paid for what you do.
Show how you're well qualified for work in a different field from your present one.

APPENDIX E

Ten Tough Questions

About Resumes

1. "How do I account for that year when I wasn't employed?"
2. "What if I was 'just a housewife' for 20 years?"
3. "What do I do about dates on my job history . . . when I had two or three little jobs with a month or so in between?"
4. "What if I was called a 'secretary' and never got the pay or job title for all the things I really did?"
5. "Can't I skip the Job Objective? I don't want to limit myself."
6. "What if I don't have any work experience in the exact job that I want now?"
7. "How long should a resume be? One page?"
8. "What if my experience was from a long time ago?"
9. "What if they insist on a chronological resume and a lot of dates?"

   and finally . . .

10. "How should I use my resume?"

---

1. "HOW DO I ACCOUNT FOR THAT YEAR WHEN I WASN'T EMPLOYED?"

Tell the truth, creatively.
BE POSITIVE; refer to what you WERE doing rather than to what you WEREN'T doing. Don't say "unemployed" because it MIGHT convey an UN-truth about you, that you aren't interested in working, when in fact we both know you WANT to work. Instead, look at what you WERE doing, allow yourself a reasonable degree of "being human," and emphasize the positive aspects of what you did that year.

EXAMPLE: Candidly from my own experience . . . in 1974 I was traveling across the country "trying to figure out what to do with the rest of my life," coping with an unexpected traumatic illness, making some embarrassing and painful and wonderful experiments in group-living, and looking — sometimes desperately — for work that I could feel good about. I got by on unemployment for awhile, Medi-Cal for the illness, off-and-on Kelly Girl work, and loans from Mom. It was a very tough year.

What does it say on my resume?

"1974 – Travel and independent study"

And that's true! I've just expressed it with more dignity than I was feeling at the time. I don't need to tell anybody, on my resume, what a bummer that year was. And believe me, I learned enough to justify calling it "independent study"!

2. "WHAT IF I WAS 'JUST A HOUSEWIFE' FOR 20 YEARS?"

Change your attitude, for starters (more below);
Give yourself credit for all you've accomplished and learned;
Then, get help expressing it all creatively.

Every woman I've worked with, who started with "just a housewife" self-image, ended up with greatly improved self-esteem after doing a DAMN GOOD RESUME. When you discard the myth that only PAID work is valuable, and start listing everything you ever did (home management activities, volunteer work, hobby and craft work, personal growth projects, reading of all kinds), an impressive body of skills, knowledges and experience emerges.

The task then is simply to identify what skills are demonstrated in all that, and learning to express them in world-of-work terms. Get help and support from places like "Displaced Homemaker" centers and community Women's Centers for the needed attitude change, and help in analyzing and writing about your skills. (Refer also to Deana's resume in Appendix A.)

3. "WHAT DO I DO ABOUT DATES ON MY JOB HISTORY? . . . WHEN I HAD TWO OR THREE LITTLE JOBS, WITH A MONTH OR SO IN BETWEEN?"

Delete very short-term jobs, OR
Combine several short jobs in one description. (See Deana's resume.)
Stick to YEARS rather than precise dates by-the-month. Rounding off to years is a good general practice anyway:

– it looks better
– it keeps the reader from doing a lot of detailed arithmetic with your work record when you want them to focus on your SKILLS. Read the Employer Feedback section; employers have different opinions on this.

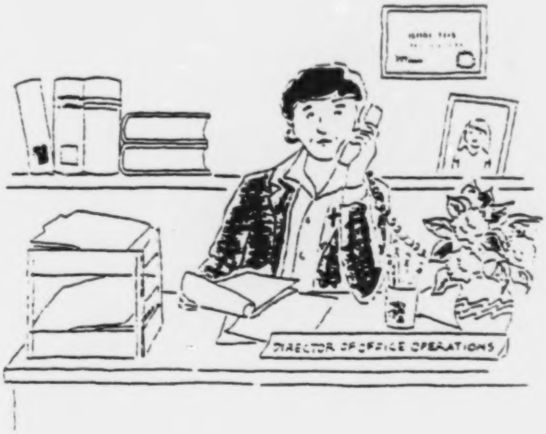
4. "WHAT IF I WAS CALLED A 'SECRETARY' AND NEVER GOT THE PAY OR THE JOB TITLE FOR ALL THE THINGS I REALLY DID?"

You don't have to use THEIR job title! So MUCH fine and important work is done every day in millions of offices by intelligent women who aren't being adequately paid or recognized for the high levels of their skills and responsibilities.

"COME THE REVOLUTION . . ." Meanwhile, feel free to create a fairer job title that reflects the highest level of skills you used as a so-called "secretary."

EXAMPLE: One client's old resume listed "secretary" positions five times. Her NEW DAMN GOOD RESUME refers to those same jobs with the following reasonable, fair job titles:

office supervisor
director's assistant
technical writer
executive secretary
administrative assistant



5. "CAN'T I JUST SKIP THE JOB OBJECTIVE? I DON'T WANT TO LIMIT MYSELF."

NO!
Clearly stating your Objective serves to FOCUS you, not to box you in. It's critically important to KNOW WHAT YOUR OBJECTIVE IS, as explicitly as possible, and to state it, and then to have everything else on your resume directly relate to it. THAT'S what makes it a DAMN GOOD RESUME.

And remember, you could have TWO or more resumes, each with different objectives. Look at George's two resumes in the Sample Resume section for examples.

6. "WHAT IF I DON'T HAVE ANY WORK EXPERIENCE IN THE EXACT JOB THAT I WANT TO DO NOW?"

A DAMN GOOD RESUME is the perfect format for you. If you really want a particular kind of job and are confident that you'd do well at it if only you got the chance, it's just about certain that you have enough transferable skills to show that you're a good candidate for the job.

Here's what your resume needs to show:

Transferable skills from paid or unpaid experience.

A credible progression from where you've been to where you want to go now. (If there's a leap the size of the Grand Canyon from where you are to the position you want, then be willing to state a current objective that bridges the gap.)

Evidence of motivation & potential—experience that used the same kind of personality traits and strengths that your Ideal Job calls for. (See Shari's resume on page 27.)

7. "HOW LONG SHOULD A RESUME BE?"

One page is best, occasionally two. And it WILL all fit—even if you have 25 years of fantastic experience. A good resume is like a handful of Aces . . . you DON'T deal out the whole deck! Prospective employers don't WANT your whole life history; they only need to see the essential points that make you qualified, plus the unique experience and attitudes that make you SPECIAL. Say the minimum, powerfully.

8. "WHAT IF MY EXPERIENCE WAS FROM A LONG TIME AGO?"

The employer's attention is turned to your SKILLS, which appear first, rather than WHEN you acquired them, with THE DAMN GOOD RESUME format. Also, you can include your more recent activities of all kinds and show how the skills you acquired are transferable to the job you now seek.

9. "WHAT IF THEY INSIST ON A CHRONOLOGICAL RESUME, WITH ALL THOSE DATES IN ORDER?"

You could point out that your resume DOES include a list of your jobs and the years you did them; it's at the end, and it's condensed. OR, you may decide to go for the chronological resume instead of the D.G.R. format. Some knowledgeable folks insist that a chronological resume is sometimes better — like when you're staying in the same field and trying to move up the career ladder.

This question usually comes up in connection with a Job Application . . . which you are going to AVOID filling out until after you've had a personal interview with the Hiring Person. THEN attach your resume instead of filling out the "Job History" section, which is invariably designed to your disadvantage. You DO NOT have to give all that information before being interviewed.

EXCEPTION: for civil service jobs, we're advised, your application won't get processed unless you fill it out fully. In that case, don't fight it . . . do it THEIR way!

10. "HOW SHOULD I USE MY RESUME?"

a) AS A "FIRST DRAFT" MODEL FOR A TAILORED RESUME. Always, when you apply for a specific advertised job opening, rewrite your resume using:

- THEIR job title as your Job Objective (word for word)
- THEIR stated skill requirements as your Skill Areas

b) AS A LAST RESORT FIRST CONTACT. When there's no way around it and you simply can't make the initial contact any other way. (But be creative . . . there usually is another way to reach the Hiring Person.) Send an excellent cover letter along with your resume.

c) BEFORE YOUR JOB INTERVIEW. To get you focused and clear. Tuck the resume in your pocket to look at just before you enter the new workplace; it will remind you of your objective and of your skills, in case you tend to space out about them.

d) AFTER YOUR JOB INTERVIEW. You can leave it with the employer as a concrete reminder and documentation of the information you provided during the interview. DO NOT hand it to the employer at the beginning of your meeting; she'll be looking at it instead of at you!

e) WHEN YOU MAKE PHONE CALLS TO STRANGERS for job information research. When lining up informational interviews, and such — especially if your morale is flagging — keep your DAMN GOOD RESUME in front of you as you work, to remind you of your skills and accomplishments, and to keep your mind from going blank about your objective.

1970

JOB INFORMATION SHEET

Company:

Position Held:

Dates of your Employment:

Description of Employer-What did company sell, produce, etc.

Duties and Responsibilities:

Skills:

Accomplishments:

Equipment Used:

Results for Company:

Criteria for effective resumes as perceived by personnel directors

Conclusions

1. Weighted averages used to measure the perceptions of personnel directors regarding the importance of various components in resume content revealed the following:

- It is important to very important to state a career objective on a resume.
- It is important to mandatory to state type of degree, major and area of specialization on a resume.
- It is very important to mandatory to state various areas of related work experience on a resume, whereas it is only important to very important to list various factors on nonrelated work experience on a resume.
- It is mandatory to state address and telephone number on a resume; however, age and applicant's picture are unimportant.
- Technical elements including neat appearance, proper data arrangement, good organization, typing and spelling were all rated as very important.
- Military experience and community involvement were important on a resume, whereas high school record and hobbies are of lesser importance. Draft status was rated unimportant.

2. Eighty-eight percent of the personnel directors spent three minutes or less reading a resume.

3. The average length of resume received was two pages long; however, generally, personnel directors prefer resumes one page long.

4. The identification section should be placed on the resume first followed by the job objective, education, experience and related activities sections.

5. Application letters which accompany the resume should identify the position sought; should relate job goals, education and experience to position desired; should demonstrate good written communication skills and technical elements; and should indicate availability for an interview and location where applicant can be contacted. ☐

Suggested content for application letters. In an open-ended question regarding an application letter which usually accompanies a resume, personnel directors primarily suggested inclusion of the following types of content:

1. Indicate how applicant could benefit the organization.
2. Identify the position being sought.
3. Relate more detail regarding applicant's career goals.
4. Explain how applicant's background relates to the job being sought.
5. Research and reveal knowledge about the company where applicant is seeking employment.
6. Indicate a willingness to travel and relocate.
7. Demonstrate good written communication skills such as proper organization, positive overall tone and conciseness.
8. Demonstrate excellent technical elements such as neat appearance, correct spelling and accurate typing.
9. Indicate availability for an interview and where applicant can be reached.

RESUME SKILL WORDS

PRODUCTION

Shaped
Reshaped
Molded
Adjusted
Guided
Defined
Constructed
Repaired
Operated
Assembled

CREATION

Initiated
Created
Developed
Implemented
Conceptualized
Invented
Planned
Established
Performed
Dramatized

ORGANIZATION

Compared
Measured
Estimated
Calculated
Computed
Analyzed
Evaluated
Investigated
Researched
Examined
Inspected
Observed
Perceived
Interpreted
Translated
Forecast
Budgeted
Assessed
Appraised
Audited
Treated
Monitored
Anticipated

ADMINISTRATION

Arranged
Organized
Coordinated
Negotiated
Contracted
Delegated
Improved
Expanded
Enlarged
Strengthened
Stimulated
Promoted
Persuaded
Achieved
Produced
Attained
Presided
Chaired
Governed
Administered
Supervised
Directed
Managed
Controlled
Maintained
Approved
Applied
Recruited
Selected
Enlisted
Distributed
Sold
Demonstrated
Displaced
Represented
Motivated

COMMUNICATION

Spoke
Taught
Instructed
Presented
Trained
Conducted
Moderated
Led
Mediated
Facilitated
Encouraged
Guided
Counseled
Communicated
Motivated
Interviewed
Edited
Wrote
Reported
Reviewed
Advised
Translated

DETAIL-ORIENTATION

Updated
Scheduled
Tabulated
Systematized
Sorted
Straightened
Classified
Compiled
Assembled
Indexed
Recorded
Summarized
Processed
Programmed
Grouped
Catalogued
Operated
Filed
Detailed
Collected

Source: Job Advisory Service

Find a Good Job in Pittsburgh
Betty Connelly/Carol F. Hershey
Revised 1989, p. 220

12 Silver Lane
McKees Rocks, PA 15136
(412)

EDUCATION:

12/84	Penn Technical Institute, Pittsburgh, Pa. Associate degree - Specialized Technology/Electronics
1981	Seton La Salle High School, Pittsburgh, Pa. Diploma

EXPERIENCE:

8/90 to Present	Ranger Contracting, Pittsburgh, Pa. Operations Manager Assistant Responsible for supervising all painting/construction projects for quality assurance, maintaining records and correspondence with customers and other contractors including written reports utilizing a personal computer and basic bookkeeping. Responsible for supervising maintenance of equipment and assisting with equipment repair. Monitor inventory control and purchase of materials and equipment.
4/87 to 8/90	Local 6 - Painters, Pittsburgh, Pa. Painter Work for various contractors performing interior/exterior and detail paintings. Gained knowledge of chemical components of painting industry including specifications of texture, grade and colorization. Work with drywall, wallpaper and frequently held supervisory positions.
3/85 to 4/87	Xerox Corporation, Arlington, Va. Service Technician Installed, set-up, repaired and maintained Xerox office machines. Successfully managed assigned territories sustaining a high level of performance and customer satisfaction. Duties also included sales of supplies and service contracts.
6/81 to 3/85	Nagy Contracting, Pittsburgh, Pa. Laborer Construction of additions to buildings, decks, remodeling of kitchens, bathrooms, interior/exterior painting, frequently held supervisory positions.
1977 to 1981	Chahine Bakery, Pittsburgh, Pa. Utility Person Repaired and maintained bakery equipment and performed duties such as stock and inventory.

REFERENCES AVAILABLE UPON REQUEST

Jan King
14 Michigan Drive
Cortland, Nevada 16003
(415) 616-5003

OBJECTIVE: To work within the arts and/or entertainment field and to help promote performing arts.

HIGHLIGHTS OF QUALIFICATIONS

- Creative, positive, energetic, and hard working
- Successful experience in sales and fundraising for arts organizations
- Resourceful in generating new ideas and solving problems

PROFESSIONAL EXPERIENCE

- Acquired all advertising for Virginia Stage Company Playbill 1990-1991 season - Assisted in layout
- Raised funding as well as acquired new support for Pittsburgh's Public Television and classical radio stations
- Inspired businesses to participate in WQED's annual auction
- Recommended musical entertainment to entertainment coordinators at The Jewish Mother
- Inspired individuals to participate as yearly subscribers to Virginia Stage Company
- Acquired funding from individuals for a non-profit theatre company
- Assisted in organizing support for Virginia Stage Company's golf fundraiser

EMPLOYMENT HISTORY

01/91 - Present	Telefundraiser WQED	Direct Advantage Marketing - Pittsburgh, PA
07/90 - 12/90	Waitress / Assistant Entertainment Coordinator	Jewish Mother Restaurant - Virginia Beach, VA
10/87 - 07/90	Marketing and Development Representative / Receptionist	Virginia Stage Company - Norfolk, VA
05/81 - 10/87	Waitress	Various establishments in Virginia Beach, VA, Pittsburgh, PA, and Wildwood, NJ

EDUCATION

9/78 - 3/80 Indiana University of Pennsylvania, Indiana, PA
Major: Computer Science

REFERENCES AVAILABLE UPON REQUEST

Peter Spates
115 Grand Avenue
Oakland, CA 04612
(415) 468-2688

EDUCATION:

University of Pittsburgh, Pittsburgh, PA
B.S. - Information Science - 1988

EMPLOYMENT:

9/88-5/91

University of Pittsburgh
Western Psychiatric Institute and Clinic
Cardiovascular Psychophysiology Research

Data Manager

Designed data entry systems using FOCUS on the University VAX/VMS mainframe computer. Programmed the database and supervised data entry. Created data sets for statistical analysis using SAS and analyzed the data for several studies. Cleaned data, prepared codebooks for documentation and ready access to data. Trained work study students in editing and file management under VMS operating system. Continued to develop databases to meet the needs of the research team.

Assisted faculty in establishing research goals consistent with data available. Effectively consulted with computer centers and technical consultants to resolve a wide range of problems. Opened and renewed VMS accounts including faculty approval and allocation of disc space.

6/87-7/88

University of Pittsburgh
Western Psychiatric Institute and Clinic
Law and Psychiatry Research

Research Assistant

Programmed and designed data entry screens for a research database using Informix on a UNIX based system. Created a database for the day-to-day management of a scholarly journal and trained staff in the operation of the system. Scored psychological and physiological data for analysis. Added responsibility of supervision of work/study students.

REFERENCES AVAILABLE UPON REQUEST

Steven Hill
200 Oakville Drive
Pittsburgh, PA 15220
(412) 921-8990

CAPABILITIES

- Monitoring and enhancing experience rating systems
- Assist in decisions regarding trend factors and outstanding claim reserves
- Develop and enhance all actuarial rating formulas
- Prepare filings for the Pennsylvania Insurance Department
- Analyze and determine monthly pool factors to E. R. S. Systems
- Properly establish corporate group health rates
- Analyze and prepare estimated and final group settlements
- Calculate and approve large group rate quotations

ACCOMPLISHMENTS

- Created an actuarial department using all data base information for one Blue Cross plan
- Restored Corporate reserve level with financially sound modification of merit-rate formulas
- Redesigned master group formulas which satisfied corporate objectives
- Devised and implemented a persistency study for marketing research

WORK HISTORY

DATES	POSITIONS	COMPANY
4/88-Present	Massage Therapist	Pittsburgh Athletic Association
11/84-4/88	Senior Analyst	Blue Cross & Blue Shield of Texas
11/79-11/84	Underwriting/Rate Specialist	Blue Cross & Blue Shield of Michigan
9/75-11/79	Worked for several Health Club Organizations	Pittsburgh Athletic Association Pittsburgh Jewish Community Center
4/73-9/75	Corporate Actuary	Blue Cross of North Eastern Pennsylvania
11/68-4/73	Assistant to the Actuary	Blue Cross of Western Pennsylvania
6/65-11/68	Calculation Approver	Prudential Insurance Company of America

EDUCATION

College: Duquesne University, Pittsburgh, PA
Bachelor's Degree in Mathematics, 1965

Insurance: Actuarial Examination Part I through 4A, Health Insurance Examination I through 4, and 3 L.O.M.A. Examinations.

John Doe
15 Dublin Road
Bethel Park, PA 15102
(412)

OBJECTIVE: To obtain a volunteer position in the Graphic Arts field.

EDUCATION: Carnegie Mellon University, Pittsburgh, PA
Bachelor of Fine Arts Degree - 1980

EMPLOYMENT:

9/91 - Present
University of Pittsburgh, Pittsburgh, PA
University Bookstore
Clerk
Responsible for working the Information Desk, handling special book orders via telephone or in person, assisting customers in locating books utilizing the computer and microfiche; inventory control utilizing IBM-PC, assure that books are properly priced and positioned in proper location on shelves.

1989 - Present
North Hills Jaycees, Pittsburgh, PA
Responsible for producing graphics for various community projects. Skills utilized include logo design, illustration, sign lettering, camera-ready art, layout and computer graphics utilizing my own PC. Also involved in writing promotional material.

1980-1989
Hampton Wines and Spirits Shoppe, Allison Park, PA
Sales Clerk
Duties included waiting on customers, operating cash register and receiving telephone orders from licensees. Also responsible for inventory control, unloading and shelving merchandise and general housekeeping.

1982-1984
Freelance Artwork for the following employers in the Pittsburgh, PA area. Assignments included key art, layout and line illustration.

Unicorn Creative Services
Tony Condello - Graphic Designer
AJB Communications
John P. Glover Associates

1979
Carnegie Mellon University, Pittsburgh, PA
Teacher's Assistant

Freelance Artwork for Pittsburgh Homicide Department, Pittsburgh, PA

1977
Freelance work for Horne's Department Store, Pittsburgh, PA
Rendered 18 pencil portraits for Heinz Hall Symphony programs.

REFERENCES AVAILABLE UPON REQUEST

Micheal, a high school graduate, omits the "Education" section and counts on his extensive work experience as professional credentials.

MICHEAL BLACKWOOD

1213 Hearst St.
Santa Cruz CA
(408) 229-1914

Objective: position as project director, in non-profit housing development

SUMMARY OF QUALIFICATIONS

- 11 years involvement with administration of non-profit housing
- Served on Board of Directors of two housing coops
- Served on planning commission of a major intentional community
- Managed or directed:
  - manufacturing business grossing $250,000/year
  - workforce of 60
  - residential community
  - environmental bookstore & business office

PROFESSIONAL EXPERIENCE

Project Management

* Served as Personnel Manager, overseeing all laborforce issues, including:
  - matching invididual preferences & work requisitions
  - designing and maintaining work-hours accounting system
  - planning & projecting labor flow
  - counseling workers on career development and training options
  - mediating conflicts among workers and managers
  - preparing budget proposals & presenting them for membership approval

* Set up books and annual budget & process at Walnut House Coop.

* Appointed & trained management committees, and monitored their progress.

Initiative & Innovation

* Started a worker-owned business and served as its first manager.

* Designed & implemented a comprehensive process of long-term resource and social planning for a residential community of 60 people.

* Helped organize an urban Limited Equity Housing Coop conversion.

Non-Profit Housing

* Personally lived in cooperative housing for the last eleven years.

* Trained in getting DRE subdivision approval.

* Familiar with the complexities of developing Limited Equity Housing Cooperatives.

* Knowledgeable in financial management of non-profit housing.

* Trained shared-housing participants in:
  - communication skills
  - conflict resolution/mediation
  - personal needs assessment
  - cooperative assertiveness
  - organizing & facilitating meetings
  - bookkeeping & financial planning

EMPLOYMENT HISTORY

1980-1984	Office Manager/Bookstore Manager	THE ECOLOGY CENTER - Berkeley CA
1974-1979	Director, Personnel Manager & Planning Commissioner	EAST WIND COMMUNITY, INC. - Tecumseh MO

1979

Estelle is still in high school, and will b working part time until graduation; she shows the relevance of her work at Mac-Donald's.

ESTELLE GADE

9843 Thirty-second Avenue
Oakland, CA 94605
415-614-2020

Current objective: Part time entry level position in Bookkeeping
1986 Objective: Full time Bookkeeping position after high school graduation

HIGHLIGHTS OF QUALIFICATIONS

- Earned an Outstanding Achievement raise at MacDonald's.
- Excellent at thinking through problem situations.
- Completed Accounting and Law classes with high grades.
- Get along with people well; fine communication skills.
- 1 year successful experience in Bookkeeping & Cashiering at MacDonald's.

EXPERIENCE

Bookkeeping

- Accurately completed bookkeeping tasks at MacDonald's in half the usual time required.
- Recorded daily sales
  - tallied total items sold and computed total daily revenues
  - recorded totals of wasted food and paper products
  - audited the cash-register records for each employee, and produced a monthly report showing where cashiering errors occurred.
- Earned an Outstanding Achievement raise at MacDonald's for consistently accurate money handling and good relationships with customers.
- Assisted in computing employee hours on time cards and verifying accuracy of vendor statements.
- Balanced family checkbook statements and paid bills.

Administrative Assistance

- Assisted store manager in orienting and assigning employees
  - prepared new employee personnel folders
  - called substitutes to fill in during illness or rush hours.
- Monitored minors' work permits to assure they were still valid.
- Filed personnel records and manager's test results.
- Posted and filed official documents.
- Typed correspondence; answered telephone; scheduled interviews; made reservations.

WORK HISTORY

1985	Fulltime student	Skyline High School - Oakland
Nov.84-Apr.85	Bookkeeper	MAC DONALD'S - Oakland
Oct.83 -Nov.84	Cashier	MAC DONALD'S - Oakland and Hayward
summer 1983	Clerk	HAVENSCOURT COMMUNITY CHURCH - Oakland
weekends 1981	Cashier/sales asst.	CERAMIC TILE CO. - Oakland

EDUCATION & TRAINING

Senior - Skyline High School, Oakland
Business courses: Accounting, Law, Typing, Journalism
President of student union organization - Co-editor of student newspaper

Suzanne knows that accounting firms hiring new grads want to see how she's done in school; so her recent education appears near the top.

SUZANNE POOLE

Campus Address:
3022 Haste St., Apt. 267
Berkeley, CA 94705
(415) 832-6743

Alternate Address:
6290 Marin Court
Concord, CA 94521
(415) 677-0905

Objective: entry level position in Audit Department

HIGHLIGHTS OF QUALIFICATIONS

- Dedicated to professionalism, highly motivated toward goal achievment.
- Successful in mastering accounting theory and technical skills.
- 3 years demonstrated effectiveness in interpersonal communications.
- Experience in coordinating projects involving people and activities.

EDUCATION & TRAINING

B.S., Accounting - University of California, Berkeley - May 1986
Honor student since Fall semester 1983 • Accounting G.P.A. 4.0 - Overall G.P.A. 3.685

AFFILIATIONS

U.C. Berkeley Honor Society - Professional Women's Assoc. - Undergraduate Business Assoc.

EXPERIENCE & SKILLS

Technical and Business Knowledge

* Developed solid theoretical grounding in financial accounting; able to set up balance sheets and income statements, and analyze clients' assets and liabilities.
* Studied laws relevant to accounting and other business applications.
* Edited market research interviews; entered coded data into computer and generated reports.

Leadership/Coordination

* Developed the confidence of owners of market research firm, and was invited to assume more responsibility through a supervisory position.
* Coordinated focus group studies for a market research firm, involving phone invitations to prospective group members & providing refreshments and study materials.
* Organized participation in a soccer team: contacted prospective players and got commitment to participate; maintained attendance records, statistics at games, and medical/equipment inventory.

Communications and Interpersonal Skills

* Successfully persuaded shoppers to volunteer time for in-person market research interviews.
* Solicited phone interviews from random samples, consistently convincing participants of the legitimacy and value of the project and the importance of their opinions.
* Gave oral reports and evaluations on market research interviews, to clients from ad agencies.
* Collaborated with co-workers to assure consistent coding of research materials.
* Assist students with their problems in accounting classes, and grade homework (current job).

WORK HISTORY

1985 fall	Reader	UC BERKELEY BUSINESS SCHOOL - Berkeley CA
1984 summer	Sales Clerk	SHOE TOWN - Concord CA
June'83-Aug'84	Interviewer	QED MARKETING RESEARCH - Walnut Creek CA
Apr'81-Mar'83	Interviewer	QUICK TEST OF CALIFORNIA - Concord CA

David was a high school dropout who recently got his "equivalency"; he focuse on demonstrating his strong m[illegible]ion, since he has very little paid ex[illegible]ence in electronics.

DAVID QUINLAN
902 Alcatraz
Oakland CA
653-8762

Current Job Objective: a position as electronics assembler
(Future goal: Electronics Technician)

QUALIFICATIONS & EXPERIENCE

* Very strong interest in electronics; I spend much of my spare time on:
  - reading and studying electronics (Popular Electronics and many books on the subject)
  - redesigning circuitry, replacing components, servicing, alignment of tuned circuits in radios, assembly and disassembly.

* Experience rebuilding and repairing:
  - tape recorders
  - stereo receiver
  - one TV
  - car radios

* Technical skills:
  - soldering
  - component identification (color coding)
  - reading schematics
  - using test equipment (oscilloscope, voltmeters, signal generators)

* Studied Electronics theory and Radio/TV Repair at community colleges.

EMPLOYMENT HISTORY

1982-85	Freelance auto mechanics and electronics repair
4/83-11/84	Assembler & driver - Spring Mountain Hot Tubs, Berkeley CA
3/82-2/83	Farm worker - Battlebrook Farm (family farm) - Bancroft ME
10/81-5/82	Fountain person - Kramer's Ice Cream, Berkeley CA
1979-82	Newspaper routeman - San Francisco Chronicle (while in school)

EDUCATION

Laney College - TV and Radio Repair - one semester, Fall 1983
Merritt College - Electronics Theory - three semesters 1981 & 1985
Berkeley High School & Berkeley Adult School - Equivalency certificate 1984

Dorian, once a union carpenter, now wants a clerical job that would pay the bills and still keep her in touch with her [illegible]reer goal while she studies to be a [illegible]ropractor.

DORIAN UHLER
1315 Martinez Lane
San Leandro CA 94579
(415) 357-0644

Objective: Position as Receptionist/Office Assistant in Chiropractic Office

Highlights of Qualifications

* 8 years experience in office settings; familiar with office procedures.
* Sincere dedication to promoting the healing process.
* Serious professional interest in chiropractic studies.
* Reliable, responsible and efficient.

RELEVANT EXPERIENCE

Office Skills

* Typed forms, letters, reports in a wide variety of office settings.
* Created and maintained filing system for corporate office and court system.
* Developed systematic method for accurately keeping track of customer records.
* Responded to changing priorities, and followed through on instructions, as research assistant to faculty member.

Client Screening & Client Relations

* Assessed health clients' need for information, offered reassurance where needed, and provided detailed descriptions of services available.
* Matched potential therapy patients (at women's health clinic) with appropriate professionals after careful assessment of their needs and the therapists' qualifications.
* Effectively handled customer complaints in a hectic business office by being sensitive to the clients' immediate needs and efficiently clearing up the problem whenever possible.

JOB HISTORY

1983-1985	Fulltime pre-chiropractic student	Merritt College - Oakland
1983-1984	Utility Construction Worker	East Bay Municipal Utilities District - Oakland
" "	Research Assistant	Dr. C. Arrington, history professor
1976-1982	Union Carpenter	Assigned to numerous construction projects
1978-1982	Consultant on Apprenticeship	(by invitation of local colleges and high-schools)
1977-1978	Intake Counselor	Berkeley Women's Center/Mental Health Unit
1974-1976	Customer Relations Rep.	Boise Cascade Office Supplies - Seattle
1973	Inventory Clerk	Genuine Auto Parts Co. - Seattle
1970-1972	Receptionist	King County Juvenile Court - Seattle
1971	Secretary	City Police Dept. - Seattle

EDUCATION

Merritt College - Pre-Chiropractic studies - 1983-85
Griffin Murphy Business College, Seattle - 1972
Seattle Central Community College - 1971-72

Mark proves his interest and familiarity with real estate, even though his primary job for the last 10 years was in wareh ing.

MARK KILLORIN

1219 Parker Street
Albany CA 94706
(415) 425-0632

Objective: Trainee in Real Estate Property Management

HIGHLIGHTS OF QUALIFICATIONS

- Experienced landlord and apartment complex manager
- Licensed in Real Estate Sales
- Certificate in Real Estate from Diablo Valley CC
- Lifelong exposure to family real estate business.
- 10 years experience in retail sales.

RELATED EXPERIENCE

MANAGEMENT

* Managed 18-unit apartment complex:
- loan collections
- yard work, maintenance
- monitor parking
- tenant complaints/requests
- screen & research potential tenants
- install appliances

* Managed warehouse:
Verified accurate delivery; enforced strict receiving rules; prepared work assignments for night crews; designed & maintained a workable schematic for warehouse stock.

* Assistant Manager sub
- supervised 35 clerks
- prepared complex merchandise orders
- entered transactions on computer
- performed detailed bookkeeping
- resolved customer & employee disputes

REAL ESTATE

* Researched and purchased two income properties (a single-family dwelling and a duplex), both generating profit.
* Developed expertise in all aspects of real estate financing.
* Assisted in accounting: loan recording and loan collections.
* Performed market analyses and square-foot analyses for property appraisals.

SALES

* Completed comprehensive course in Real Estate Sales at Diablo Valley College.
* Sold retail products and developed excellent customer rapport for 10 years.
* Participated regularly in team competition for creative marketing displays in a retail store.
* Studied sales reports and reorganized retail stock displays to maximize sales volume.

EMPLOYMENT HISTORY

1975-1985	Warehouse Manager	PARK & SHOP MARKET, Oakland
1983 summer	Asst. Manager	PARK & SHOP MARKET, Oakland
1977-1978	Office Assistant, part time	E.J., KILLORIN Co., Real Estate Loans, Berkeley

EDUCATION & TRAINING

A.A. degree, Business Administration - Diablo Valley College, Pleasant Hill
Real Estate Certificate Program, DVCC | Real Estate Licensing Program, Anthony Schools, Oakland

1984

12 Chestnut Drive
Pittsburgh, PA 15205

EXPERIENCE:

8/91 to Present

MEDICAL TECHNOLOGIST
St. Francis Medical Center, Pittsburgh, PA

- Therapeutic Drug Monitoring using a COBAS MIRA
- Drug Screening procedures using TOXI LAB and GC/MS methodology
- Responsible for the testing and reporting of laboratory results in clinical chemistry including urinalysis
- Perform Phlebotomy

11/90 to 3/91

LABORATORY SUPERVISOR/MEDICAL TECHNOLOGIST
DeYor Southwestern Laboratory, Pittsburgh, PA

- Responsible for directing the general operation and testing procedures in the laboratory in the following areas:
  Chemistry, Hematology, Urinalysis, Coagulation, Serology and Specimen Processing
- Perform Phlebotomy
- Responsible for Quality Control

12/86 to 7/90

MEDICAL TECHNOLOGIST
Presbyterian University Hospital, Pittsburgh, PA
Clinical Chemistry, Central Laboratory Services, Inc.
Toxicology Department

- Therapeutic drug monitoring using the Abbott TDX
- Tricyclic antidepressants and cyclosporine extraction procedures with analysis using the Waters H.P.L.C.
- Lithium and other element analysis using Atomic Absorption
- Maintenance and troubleshooting instruments

Special Chemistry Department

- Thyroid function testing procedures
- Tumor marker testing procedures
- Gas Chromatography urinalysis for VMA/HVA

Automated Chemistry using the Kodak EKTACHEM
Quality Control Coordination
Responsible for teaching Medical Technology students

3/86 to 11/86

MEDICAL TECHNOLOGIST
Uniontown Hospital, Uniontown, PA

- Responsible for all testing and reporting of laboratory results in the following areas: Chemistry, Hematology, Microbiology, Serology, Urinalysis, and Blood Bank
- Perform Phlebotomy

EDUCATION:

INDIANA UNIVERSITY OF PENNSYLVANIA
Bachelor of Science in Medical Technology, 1984
ASCP and NCA certified
Dean's List

REFERENCES PROVIDED UPON REQUEST

applications

1986

ANATOMY OF AN APPLICATION FORM

Although there are many different kinds of application forms, the rules for filling them out are usually pretty much the same. The following informational categories are typical of what you will find when you start applying for jobs.

General Information
The employer is trying to get the necessary facts about you.

Personal Information
Is generally considered to be unfair to ask until you are hired or unless it is necessary to the job. You can choose to answer or leave this blank if you are not comfortable providing this type of information. You can also state "WILL PROVIDE WHEN HIRED."

Physical Condition Questions
Answer in brief nonmedical terms followed by a positive statement about your capabilities. This information is fair to ask IF IT WOULD AFFECT THE WAY YOU CAN DO THE JOB. Remember, be sure to tell what you can do as well as what you cannot do.

Position Applied For
Be sure to list one or two job titles in which you are interested. Never state "anything."

Salary Question
Never fill in a dollar amount. Instead state "Open" or Negotiable."

Work History
This is a very important part of the application. Answer these questions truthfully and completely. Bring the information with you on a "Help Sheet" so you are prepared. Be sure to list the skills and JOB DUTIES you performed in your job. Don't take shortcuts on your answers--this section is very important in selling you to the employer. Also, never say "See Resume"--take the time to fill in the form even if you simply restate what your resume already says. Don't make the employer work to learn about you--it may irritate them.

If you don't have any or many paid work experiences, include volunteer work under this section.

> Reason for Leaving - If your reason for leaving a job was not positive, be careful how you say it. NEVER put down anything which might concern the employer before you get a chance to interview. Instead, put down "Will explain in interview" or leave it blank.
>
> Employment Dates - The employer will be watching for gaps in your work history--these will have to be explained in the interview. Be Honest - The employer will probably check up on this section.
>
> References - Be prepared to list three people who know you and would say positive things about your work, skills and personality. Be sure to get permission from the reference people you list so they are not confused, surprised, or unhappy about getting a reference call from an employer.
>
> Organizations - Do not list church or political groups just in case the employer doesn't agree with your religious or political beliefs. You may be discriminated against if the employer doesn't share your views.

Training
The employer is trying to determine if you have the proper training and/or education for the job. You may have too much or too little. The employer may send for school records--or ask you to--in order to verify the information you provide, so be certain the information you give is correct. If you have your General Equivalency Diploma (GED) be sure to so indicate. Most employers believe the GED is as good as a high school diploma, but they will probably ask you why you quit high school during the interview.

If you plan to continue schooling while working, be sure to stress that you would do this only around your work schedule.

Hobbies and Interests - List 4 or 5 interests that you have.

Military Service - If you were in the military, indicate the training you received and the work you did.

Physical Capabilities - Questions about what you can do physically are fair if they will not be used to disqualify someone from a job they could do.

Convictions - If you were convicted of a crime as an adult, say "Will explain in interview." Arrests with no conviction or juvenile offenses do not need to be reported.

Statement of Truth and Signature - Be sure to sign the application before turning it in to the employer. This is your statement that all the answers you provided are correct. You may also be giving permission to the employer to check references.

Remember, providing false answers on an application form gives the employer the right to fire you later. Take your time and do a good job as this is a very important part of getting a job. Again, be honest!

DATE

LAST NAME

FIRST

MIDDLE INITIAL

SOCIAL SECURITY #

EMPLOYMENT APPLICATION

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
a division of the
UNIVERSITY OF PITTSBURGH

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Western Psychiatric Institute and Clinic, as an educational and mental health care institution and as an employer, does not discriminate on the basis of race, color, religion, ethnicity, national origin, age, sex, marital, or handicapped status. This commitment is made by the Institute and required by Federal, State, and local laws and regulations, including Title IX, 86.9.

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE WESTERN PSYCHIATRIC INSTITUTE AND CLINIC TO INVESTIGATE ANY OR ALL STATEMENTS I HAVE MADE WITH THE UNDERSTANDING THAT ANY MISREPRESENTATION MAY BE CAUSE FOR DISMISSAL OR REFUSAL TO EMPLOY. I AGREE TO MEDICAL EXAMINATION(S) AND/OR ANY OTHER PRE OR POST-EMPLOYMENT QUALIFYING EXAMINATIONS THAT MAY BE REQUIRED AS A CONDITION OF INITIAL OR CONTINUED EMPLOYMENT. IF EMPLOYED, I UNDERSTAND THAT HOURS OF WORK AND OTHER WORKING CONDITIONS ARE SUBJECT TO CHANGE AT THE INSTITUTE'S DISCRETION.

DATE ____________________ SIGNED ____

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC is in no way obligated by the filing of this application, and acceptance thereof does not indicate that there are positions open. Separate application must be made to the University of Pittsburgh Personnel Division, Cathedral of Learning for all university positions other than positions at WPIC. The information contained herein will be held confidential and is, together with all attached papers, photographs, etc., the property of the INSTITUTE. This application will remain active for one year.

WPIC–(Per Div 11/76)
ITEM #812400

PERSONAL DATA

LAST NAME	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NO	PHONE (AREA CODE AND NO.)
ADDRESS–STREET	CITY	STATE	ZIPCODE	

U.S. Citizen. If "No" give Alien Reg. No. (or Type of VISA)
☐ Yes
☐ No

PHYSICAL CONDITION (SPECIFY LIMITATIONS)

HAVE YOU EVER COLLECTED WORKMEN'S COMPENSATION (If "Yes" give date and nature of injury)
☐ Yes ☐ No

HAVE YOU EVER BEEN CONVICTED FOR VIOLATION OF ANY LAW OTHER THAN MINOR TRAFFIC VIOLATIONS (If "Yes" give details)
☐ Yes ☐ No

JOB INTEREST

POSITIONS APPLIED FOR
1. 2 3

PLEASE INDICATE PREFERENCE
☐ FULL TIME ☐ PART TIME ☐ PERMANENT ☐ TEMPORARY

MINIMUM SALARY ACCEPTABLE
$

DATE AVAILABLE FOR EMPLOYMENT

HAVE YOU EVER PREVIOUSLY APPLIED FOR EMPLOYMENT AT THE UNIV. OF PITTSBURGH OR UNIV. HEALTH CENTER?

HAVE YOU EVER BEEN PREVIOUSLY EMPLOYED AT THE UNIV. OF PITTSBURGH OR UNIV. HEALTH CENTER?

REFERRAL

HOW WERE YOU REFERRED TO THE WESTERN PSYCHIATRIC INSTITUTE AND CLINIC?

ADVERTISEMENT ______________________ NAME OF PUBLICATION
AGENCY ______________________ NAME
EMPLOYEE ______________________ NAME
OTHER ______________________

EDUCATION

	NAME OF SCHOOL AND ADDRESS	FROM MO.	FROM YR.	TO MO.	TO YR.	DEGREE/ DIPLOMA	NO. OF CREDITS	Q.P.A.	MAJOR	MINOR
HIGH SCHOOL							NA			
COLLEGE OR UNIVERSITY										
GRADUATE SCHOOL										
TECHNICAL, TRADE, PROFESSIONAL, MILITARY, OR BUSINESS SCHOOLS										

LICENSES OR CERTIFICATES	AGENCY	DATE

SKILLS

LANGUAGES–SPEAK	READ	WRITE	
DRIVER'S LICENSE ☐ YES ☐ NO	STATE	BUSINESS EQUIPMENT	TYPING W.P.M.
SHORTHAND W			

1990

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EMPLOYMENT HISTORY

LIST PREVIOUS EMPLOYERS—MOST RECENT FIRST Account fully for your time since leaving high school or for a maximum of 10 years.

EMPLOYER'S NAME | ADDRESS

TYPE OF BUSINESS | DATES EMPLOYED — FROM | TO | FINAL SALARY

JOB TITLE AND DUTIES (INCLUDING SUPERVISORY)

SUPERVISOR'S NAME | SUPERVISOR'S PHONE NO. | REASON FOR LEAVING

EMPLOYER'S NAME | ADDRESS

TYPE OF BUSINESS | DATES EMPLOYED — FROM | TO | FINAL SALARY

JOB TITLE AND DUTIES (INCLUDING SUPERVISORY)

SUPERVISOR'S NAME | SUPERVISOR'S PHONE NO. | REASON FOR LEAVING

EMPLOYER'S NAME | ADDRESS

TYPE OF BUSINESS | DATES EMPLOYED — FROM | TO | FINAL SALARY

JOB TITLE AND DUTIES (INCLUDING SUPERVISORY)

SUPERVISOR'S NAME | SUPERVISOR'S PHONE NO. | REASON FOR LEAVING

EMPLOYER'S NAME | ADDRESS

TYPE OF BUSINESS | DATES EMPLOYED — FROM | TO | FINAL SALARY

JOB TITLE AND DUTIES (INCLUDING SUPERVISORY)

SUPERVISOR'S NAME | SUPERVISOR'S PHONE NO | REASON FOR LEAVING

OD(S) of UNEMPLOYMENT

Account for all intervals of unemployment, if any

From		To		State what you were doing
Mo	Yr	Mo	Yr	

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GENERAL

CONFERENCES/SEMINARS IN WHICH YOU HAVE PARTICIPATED THAT ARE APPLICABLE TO THE JOBS FOR WHICH YOU ARE APPLYING. INCLUDE DATES

TITLES OF REPORTS AND SPECIAL PROJECTS TO WHICH YOU HAVE CONTRIBUTED

ORGANIZATIONS OF WHICH YOU ARE A MEMBER (DO NOT INCLUDE ANY ORGANIZATIONS THAT REVEAL SEX, RACE, ETHNICITY, POLITICAL OR RELIGIOUS AFFILIATION)

PUBLICATIONS

EXTRA CURRICULAR/RECREATIONAL ACTIVITIES AND ACCOMPLISHMENTS

DO NOT WRITE BELOW THIS LINE

JOB REFERRAL INFORMATION

DATE	POSITION	DEPT.	INTERVIEWER	RESULT

Recruiter's Remarks

Annual Salary	☐ F.T ☐ P.T ____ Hrs	Dept. No	Salary Review Mo	Salary Class	Job Code	Sex & Marital Status	Date Employed

Department	Job Title	Source Code	Replacement Data

Program Director's Signature	Administrator's Signature

1992

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APPENDIX E: Sample Employment Application

Name____
Last First Middle

Address____
Number and Street

____
City State Zip

How long at this address?_____________________________________

Social Security No.:____

Home Phone:_____________________Work Phone:___________________

Do You Have a Car?____________Driver's License?_______________

Health:__________Days Missed Due to Illness Last Year:_______

Date and Nature of Last Major Illness:________________________

List Physical Limitations which would prevent you from performing this job:

____

Have You Ever Received Workman's Compensation for Injury?

_________If yes, describe:______________________________________

Were you ever convicted of a criminal offense or have you ever forfeited bond or collateral in connection with a criminal charge?________________If yes, attach details on a separate sheet.

MILITARY

Military Service Branch:______________________________________

Dates:____

APPENDIX E: Sample Employment Application (Continued)

EDUCATION

Highest Grade Completed:____________________

College: Name:______________ Address:______________________

High School: Name:______________ Address:______________________

Technical or Voc. School: Name:________ Address:______________

Other Schools: Name:____________ Address:______________________

Name:______________ Address:______________________

Year Graduate: H.S.________ College:________ Tech or Voc:______

Degree/Diploma:____________ Major:__________ Minor:__________

Professional Licenses and Certificates:______________

EMPLOYMENT HISTORY

(Begin with your present or most recent employment.)

Employer:____________________ Address:______________________

Job Title:__________________ Dates: From__________ to__________

Duties:____

Salary:__________ Reason for Leaving:______________________

Employer:____________________ Address:______________________

Job Title:__________________ Dates: From__________ to__________

Duties:____

Salary:__________ Reason for Leaving:______________________

(Attach additional sheets as necessary)

I certify that the above information is correct. I realize that providing false info is grounds for later dismissal.

Applicant signature:________________________ Date:____________

1994

APPLICATION FOR EMPLOYMENT

DUQUESNE UNIVERSITY

DATE ____________________

PERSONAL INFORMATION

Name ________________________ Social Security No. ____________

Address ________________________ Zip Code ________ Phone No. ________
(Street) (City)

Are you between the ages of 18 and 70? ______ If not, what is your age? ________

Are you a citizen of the United States? ____ If not, what is your VISA? ________

Are there any positions for which you could not be considered because of a physical handicap? Please explain: ________________________

Have you ever been convicted of a crime? ________ Please explain: ____________

Whom may we contact in case of emergency? ________________________

WORK PREFERENCE

Position(s) applied for ________________________

Full-time _____ Part-time _____ Part-time Only _____ Hours Available ________

Earnings Expected ________________ Date Available ____________

EDUCATION

TYPE OF SCHOOL	NAME OF SCHOOL	COURSE/DEGREE	LAST YEAR ATTENDED	YEAR GRADUATED
High School				
Business/Technical				
College/University				
Other				

Presently attending school? ________ Where? ________________

MILITARY EXPERIENCE

Have you served in Armed Forces of United States? _______ Discharge __________

Does any of your military experience have any relationship to the position(s) for which you have applied? ________________________

SPECIAL QUALIFICATIONS

Please list special knowledge, ability and/or skills (whether or not related to the position(s) for which you have applied) including any acquired through volunteer work:

	CURRENT OR PREVIOUS EMPLOYERS	EMPLOYED FROM	EMPLOYED TO	POSITION	WAGES OR SALARY	REASON FOR LEAVING
EMPLOYMENT RECORD	Name and Complete Address:					
		Immediate Supervisor and Phone Number:				
	Name and Complete Address:					
		Immediate Supervisor and Phone Number:				
	Name and Complete Address:					
		Immediate Supervisor and Phone Number:				
	Name and Complete Address:					
		Immediate Supervisor and Phone Number:				
	Name and Complete Address:					
		Immediate Supervisor and Phone Number:				

REFERENCES

LIST THREE PROFESSIONAL AND/OR BUSINESS REFERENCES OTHER THAN EMPLOYERS

NAME	ADDRESS	PHONE NO.	OCCUPATION

Source of Referral to Duquesne ______________________________

TERMS OF APPLICATION

The acceptance of your application for employment in no way obligates Duquesne University and any attached papers become the property of the University and any misrepresentation by you in this application will be sufficient cause for cancellation of your application and/or for separation from the University's service if you have been employed. Also, the results of all examinations which are a necessary part of your application for employment, including physical and/or psychological examination, will be released to the Office of Human Resource Management for evaluation before an offer of employment is made.

AUTHORIZATION AND SIGNATURE

I understand the terms of my application for employment with Duquesne University and I hereby authorize the release to the University of any information regarding my educational and/or employment background which is pertinent to my application.

______________________________ ______________________________

Signature Date

D. U. is an Affirmative Action/EEO Employer

DS 07 0168 (Rev. 5-01-86)

REASONS FOR LEAVING JOBS

Employers will take special note of your cited reasons for leaving past jobs. They will be watching for indications that you may have had difficulty getting along with other persons, for health problems and for other signs of "trouble." Take care when you indicate these reasons on an application form as well as while answering questions during an interview.

NEVER USE	USE INSTEAD
Fired **Injury** **Health Problems** **Personal Problems** (May alarm employer that you have a pattern of poor health or recurring injuries.)	**Will Explain in Interview**
Laid Off (May appear that you alone were fired or asked to leave job.)	**Not Enough Work** **Large Company Lay Off** **Job Phased Out**
Not Enough Money or Benefits **Didn't Like Job** **Didn't Like Company** **Didn't Like Boss** **Quit** (May appear that you have a bad attitude or don't get along with others.)	**Will Explain in Interview** **or** **Job Advancement** if you went to a job offering more money, better position, more benefits, better company, opportunity for job advancement.
	Other good reasons for leaving jobs: **Moved or Relocated** **Care for my Family** **School or Training** **Seasonal or Temporary Employment**

Many people dislike the "paperwork" involved in a job search. However, it is not too difficult if you follow some basic guidelines. Let's look at the paperwork typically required during an employment search.

FILLING OUT JOB APPLICATION FORMS

THE COMPLETED JOB APPLICATION FORM IS PROBABLY THE FIRST IMPRESSION AN EMPLOYER WILL HAVE OF YOU--SO MAKE IT A GOOD ONE! IT IS IMPORTANT TO ANSWER ALL OF THE QUESTIONS CAREFULLY AND POSITIVELY.

The way you fill out your application may tell the employer:

- how neat you are
- how well you read, write and spell
- how careful you are
- how prepared and organized you are
- how well you follow directions

Be sure to TAKE YOUR TIME AND DO A GOOD JOB FILLING OUT THE APPLICATION form or you may never get a chance to interview. Even one error on the application form can cause an employer not to select you for the interview.

Although there are thousands of different types of application forms, most of them are somewhat similar. Let's take a look at a typical one. Ask your instructor to show you more samples of the ones from your own community.

TIPS ON FILLING OUT APPLICATION FORMS

DO	DON'T
Do take a "Help Sheet," your resume, and an erasable pen with you.	Don't be caught unprepared without a pen and the correct information.
Do read the entire form carefully before you start filling it out.	Don't hurry through the form and make mistakes which show you don't follow directions well.
Do use your best printing and be neat.	Don't scratch out or write over mistakes--use an erasable pen. Don't fold, tear or smudge the application form.
Do follow all directions carefully.	Don't be afraid to ask questions if you don't understand.
Do tell the truth and be positive about yourself.	Don't confess everything on your application. If your written answer won't explain things positively, write "Will Explain in Interview" on your application form.
If you cannot answer a question positively, you may choose to leave a blank space. Do be prepared to answer and discuss these questions in an interview though.	Don't expect employers to forget about blank spaces on your application form or about times in your work history when you have not worked.
Do re-read the application form before you turn it in to make sure it presents you in a positive way.	Don't turn in an application with spelling errors, cross-outs or negative sounding information.

APPLICATION CHECKLIST

Always check the following items before you turn in your application form:

IS MY APPLICATION FORM:

- _____ filled out completely
- _____ clean and neat with no cross-outs or smudges
- _____ easily readable
- _____ filled out correctly--no spelling errors
- _____ truthful - yet does not list health or personal problems
- _____ positive and adequate in answers; states "open" as desired salary
- _____ signed by me

REFERENCE CHECKS

Have you ever wondered what may be asked about you when an employer "checks" your references? The following are some typical questions that may be asked of a former employer.

1. How do you know him/her?

2. How long have you known him/her?

3. What kind of worker/person was he/she?

    _____ Dependable
    _____ Reliable
    _____ Accurate
    _____ Quality
    _____ Speed of Work/Quantity

4. How did he/she work without supervision?

5. How did he/she get along with others?

    _____ Co-workers
    _____ Supervisors

6. General impressions? Any problems? Any concerns?

7. How often was he/she late for work?

8. How often did he/she miss work in the past year?

9. Would you rehire him/her?

MORE ABOUT CHOOSING REFERENCES

A reference is a person who knows you and can say things about your qualifications based on his/her experience working with you or simply knowing you. A good reference has credibility and will say positive things about your abilities and personality characteristics.

There are three types of references you can use:

1. **Employer** -	These are people you have either worked for or with. List ones who have good things to say about your honesty, dependability and skills. If you are not sure what a former employer might say, ask them before you use their name. This type of reference is usually the most reliable reference available.
2. **Training** -	These are people who have known you during your schooling such as teachers, administrators, or guidance counselors. Use this type of reference only if you've been in school within the past two years.
3. **Character** -	These are people who have known you a long time and can talk about your honesty, work efforts, and dependability. Be sure to use their business titles to add credibility to this type of reference.

Do not list relatives, spouses, or significant others as references. These people will be expected to say good things about you and they lack credibility because of your relationship with them. Also, avoid using names of clergy or persons with strong political affiliations as the employer could possibly discriminate if he/she holds different beliefs.

appendix 40

WRITTEN REQUEST FOR A LETTER OF RECOMMENDATION

Company's Name
Company's Address
____
____
____

Dear Mr. Forsyth:

I'm writing this note as I told you I would on the phone. Thanks for agreeing to give me a letter of recommendation. Since I'll be giving the letter to different companies, could you address it "To Whom it May Concern"?

To refresh your memory about some details, you first met me in the American Legion in 1968, about 9 years ago, when I joined while you were President. We worked together on several committees, especially the Social Committee, when we planned outings. You have met my wife, Doris, and my three children at our picnics and at parties, and you know my department foreman, Ralph Henshaw, very well.

In the letter you might want to comment on whether I am trustworthy and conscientious, and on how I get along with people, since this information is very important to job interviewers. Also, if you could write your letter on your company stationery that would have your telephone number, title, and address on it so the interviewer could contact you if he needs to.

I really appreciate your writing this letter. It will mean a lot to me. As you can see, I'm trying very hard to get a job, so if you hear of anything, I'd like to know about it, either where you work or other places. Since you don't know all of the things I've done in jobs before we met, I'm sending a couple of job résumés I've made up. They will tell you a little bit more about me, and you can give them to anyone you hear about that might have the kind of job I can fill.

I'm including a stamped and self-addressed envelope so you can return your open letter to me easily as soon as you get it typed up. Thanks again and give my best to Joan and the kids. See you at the bank.

Regards,

Your Name
Your Address

Example of an "illegal" application

CALL ON EVERY NEW HIRE

DATE CALLED

VALIDATION NO

L.T.W.
1-800-347-4473
1-800-223-0236

EMPLOYMENT APPLICATION

Name Last First Middle

Present Address Street

City State Zip

Telephone Number Social Security Number

For purposes of local taxes, please identify the city, borough or township in which you reside:

Have you paid Occupation Tax this calendar year? Yes ☐ No ☐ If yes, to what city, borough or township?

Position(s) for which you are applying:

If hired, on what date will you be able to start work?

State Geographical Preference if any:

RECORD OF EDUCATION

Circle Highest Level of Education Completed	Elementary School	High School	College
	1 2 3 4 5 6 7 8	9 10 11 12	1 2 3 4

	List Name & Address of School	Diploma or Degree
Elementary School		
High School		
College		
Other Specify		

SECURITY INFORMATION

Have you ever been convicted of a felony or misdemeanor other than a minor traffic offense?
Yes ☐ No ☐ If yes, list date, city, charge and disposition:

Do you have the legal right to be in this country? Yes ☐ No ☐

Type of Visa Visa Number Date of Expiration

To enable us to make reference checks, list any name change, assumed name, or nickname by which you are known:

MILITARY INFORMATION

Have you served in the US Armed Forces? Yes ☐ No ☐ Branch of Service

From To Rank at Induction Highest Rank Attained

Are you in the Reserve or National Guard? Yes ☐ No ☐ Total Months of Active Duty

Branch Ready Standby Retired

WORK HISTORY — (Do Not Skip Any Jobs) whether temporary, seasonal, paid, unpaid or voluntary

DO NOT SKIP ANY JOBS	Company's Name Street Address, City, State, ZIP Code	Supervisor's Name Company Phone No.	Name of Job You Held Responsibilities	Date Started Mo./Yr.	Date Left Mo./Yr.	Last Pay Rate (Salary)	Why Did You Leave? (Or Want to Leave?)
Present or last job held							
Previous job before the one above							
Previous job before the one above							
Previous job before the one above							

May we call/write your present supervisor? ☐ Yes ☐ No Phone No. ____________

If not, please write down the name and phone number of someone who has known you two months or longer and who could tell us about you. ____________ Phone No. ____________

PERSONAL REFERENCES (Not Former Employers or Relatives)

Name and Occupation	Address	Phone Number

HEALTH QUESTIONNAIRE (Each of the following questions should be answered "yes" or "no." "Yes" answers, unless self explanatory, should be clarified in the space provided on the following page.

Do you have any physical limitations that would prevent you from or be aggravated by lifting such as:

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Shoulder Problems	☐	☐	Heart Disease	☐	☐
Hernia or Rupture	☐	☐	Neck Problems	☐	☐	Back Problems	☐	☐
Knee Problems	☐	☐	Other ____________					

Do you have any physical condition which would prevent you from standing for long periods, such as:

	Yes	No		Yes	No		Yes	No
Varicose Veins	☐	☐	Swollen Ankles	☐	☐	Swollen Joints	☐	☐
Rheumatism	☐	☐	Phlebitis	☐	☐	Other ____________	☐	☐

Do you have any physical condition which would prevent you from working in cold (less than normal room temperature) and/or damp areas, such as:

	Yes	No		Yes	No
Arthritis	☐	☐	Rheumatism	☐	☐
Tendency towards Pneumonia or other chest ailments	☐	☐	Other ______________	☐	☐

Do you have any communicable disease which may result in your not being permitted to work with food, such as:

	Yes	No		Yes	No		Yes	No
Tuberculosis	☐	☐	Skin Allergies	☐	☐	Other ______________	☐	☐

Do you have any other physical or emotional condition which requires a restriction of any of your activities?

	Yes	No		Yes	No
Fainting Spells	☐	☐	Severe or Recurring Headaches	☐	☐
Asthma	☐	☐	Breathing Difficulty or Emphysema	☐	☐
Epilepsy	☐	☐	Convulsions or Blackout Spells	☐	☐
Emotional Disorder	☐	☐	Stomach or Intestinal Trouble	☐	☐
Any Fractures	☐	☐	Other ______________________________	☐	☐

Do you have any of the following that might reduce your ability to operate electronic equipment:

	Yes	No		Yes	No
Vision Impairment	☐	☐	Dyslexia	☐	☐
Eye to Hand Coordination	☐	☐	Hearing Difficulty	☐	☐

"If you have received treatment in a hospital or by a physician or other practitioner at any time during the last three years for any of the illnesses or conditions described in the questions, please complete the following to enable us to ask your treating physician to certify your fitness for employment." (If no such illness or condition required treatment in a hospital, or by a physician or other practitioner, write "none.")

Date(s)	Hospital	Condition	Treating Physician/Practitioner

If you need to clarify any of the answers on the health questionnaire, please use the space provided:

____

____

____

____

Have you ever claimed compensation for injuries from an employer or any other party?

Yes ☐ No ☐ If yes, describe in full: ____

____

____

____

IMPORTANT - READ BEFORE SIGNING

AFFIDAVIT

1. The statements I made in this application are true and complete. I understand that if, in the judgment of the company, I have made any false statement, omission, or concealment or I have failed to answer any question fully and accurately, it will be grounds for terminating my employment if I am hired.

2. I authorize investigation of all statements and matters contained in this application, which Phar-Mor may deem relevant to employment. Phar-Mor will keep all such information confidential, except when such information is required to be released by law, order of a court, or other authority.

3. I agree to submit to a physical examination if requested by Phar-Mor. Phar-Mor shall designate the physician and shall also pay the examination expense. A physical examination may be requested prior to acceptance of employment or at any subsequent intervals after employment is granted. The purpose of such an examination (or examination) will be to determine my physical fitness to begin or continue employment with Phar-Mor.

Signature of Applicant

Date

FOR COMPANY USE ONLY (THIS SECTION NOT TO BE COMPLETED BY APPLICANT)

Interviewed By:

Date:

REMARKS:

REFERENCE CHECK(S)

HIRE DATE

POSITION

RATE OF PAY

DEPARTMENT

DATE OF BIRTH

2007

TAPIT

Common Job Hunting Liabilities and How to Handle Them

4

2008

Applied Information
Technologies

Common Job-Hunting Liabilities and How to Handle Them

When it comes to job hunting, few people realize the importance of dealing with their liabilities. Sometimes these problems are viewed as relatively unimportant and are overlooked. On other occasions a person's liabilities are mistakenly thought to be so very serious, that a job hunter concludes that no corrective action can be taken.

To be most successful, you should develop a strategy for handling any potential liability you may have before you ever attempt to write your resume . . . take an interview . . . or in any way conduct your job campaign.

In the pages that follow, you will find overall solutions to common liabilities. Important observations are made, specific recommendations are offered, and in some cases, alternative courses of action are considered. If there appears to be overlap, it is best to review all of the information that may relate to your situation.

To get started, we suggest you review each liability listed. If it applies to you, place a check mark along side the appropriate number. In the majority of instances, you will have more than one item of concern that you should review. If you are not sure that it relates to your situation, read over the information presented and utilize only that which is pertinent.

When you surface ideas that you believe will help you, either underline the points or make notes on a separate piece of paper. Once you have covered all necessary material, you should be in a better position to formulate a strategy for offsetting your own job hunting liabilities.

Keep in mind that there is virtually no career problem that has not already been successfully resolved by someone else. As you review the strategies, you will soon realize that every liability can be overcome if you will commit to taking action that will resolve them. That commitment, combined with a firm belief in yourself and your future, will be a powerful force in helping you prevail over any difficulties and become successful in the job market.

1

You Are Attempting to Return to a Previous Occupation

Not many people have the courage to switch occupations, but among those who do, some find that they really don't like the new job as much as their previous one. When that is the case, it's best to admit the mistake and return to the previous occupation. The problem, of course, is that your most recent experience no longer relates to your goal.

One of the more common situations is the former "producer" who finds that "management" is not so satisfying and rewarding as expected. Many times, your own employer is unwilling to return you to your old job. That means the only way to reach your goal is through a well-executed job change. (Educators sometimes reach the same conclusion and find that they want to return to teaching.)

The important thing, in any case, is to remember that your recent experience should not detract from what you achieved previously. In fact, you normally will have developed a broader perspective, which will make you potentially more attractive as an employee in your past occupation.

There are a number of steps you can take to handle this situation. In the resume, you can use a format which presents goal-related achievements first.

Use the heading "Pertinent Accomplishments" or "Relevant Achievements" as a device to help justify the lack of emphasis on your most recent position. When communicating your recent experience, demonstrate that it complements your capabilities to excel in your previous occupational area. More often than not, you will have gained additional insights that would not be possessed by someone who never left the field.

Portray yourself as whatever you once were, plus more. Sell the fact that you will be an extra value, highly productive and multifaceted employee. Show when possible that you are able to deliver more benefits per dollar of compensation.

During the interview, you may be able to turn this to an additional advantage by characterizing the recent experience as "getting it out of your system." You can focus 100%, without looking over your shoulder, wondering whether you might have been happier doing something else.

You may also find it helpful to review the COMPASS database for your occupation, making careful note of the major requirements for the position you seek. Be certain that your qualifications for each requirement are evident on the resume and in your interviews.

2

Your Career May Have Peaked

This is an increasingly common situation today. You probably realize that developments in technology have been reducing the role of many middle managers in the traditional heavy industries. Also, financial pressures have been reducing the number of supervisory levels in many organizations.

If you encounter such a situation, it is likely that you will have to change industries. Another option would be to seek a broader role in a smaller company in your field. Because of the many changes in our economy, employers are adopting more progressive attitudes toward those whose careers appear to have peaked. People realize that it can happen to anyone.

Your resume should emphasize achievements over a broader period of time, rather than focusing on the last two or three years. A positive mental attitude is particularly important in this situation. A defeatist view can establish itself if you are not careful. Once that happens, your troubles can only become greater.

Realize that careers peak for a variety of reasons. If you are a high-level corporate officer, it just may be that you will never go any higher, nor do you wish to do so. Here, boredom may be the problem and a lateral move to a new environment could be all that you are after. The challenge of a new company, new associates and different problems could meet your expectations fully.

When industries and companies experience declining revenues, a majority of the employees will face a disappointing future. The longer you accept this stagnation, the more likely it is that others will view you as "peaked." The best solution is to recognize your plight early and decide to do something about it.

During the interview you should seek every advantage possible. Don't hesitate to point out that achievements are more difficult to come by in stable or declining fields. That would suggest the impact of your presence would have much greater intensity in a growing organization. Don't be reluctant to communicate your strengths and be certain to work toward maintaining a positive belief in yourself.

For most people, careers are a series of steps and plateaus. If you are stuck on a plateau, summarize all of your past accomplishments that were most significant to you and your employers. Describe the things you did to earn raises and promotions. Analyze requirements for the position you want, then surface every scrap of information on education, exposure or direct experience that might justify your candidacy.

3 Your Achievements may be Difficult to Quantify

You are far more likely to impress potential employers if you can show measurable results which were achieved as a result of your actions. However, for some, it is difficult to attach a specific dollar, percentage, or numerical figure to their actions. If it is early in your career, you will want to emphasize attitudes, interests and aspirations. Work ethic is always a factor that you can communicate.

Even if you've worked for some years and lack quantifiable achievements, you can still make it easy for employers to understand your potential. On the resume, you can make a comparison between conditions existing before you started and those which existed afterwards. Any measure of visible change can reflect favorably on your candidacy.

You can examine all aspects of your job and concentrate on those that were personally most satisfying. Or, you can reflect on those actions that seemed to please your superior the most. These avenues of thought can usually lead you to claim some benefit that your employer received as a result of your work.

No matter what your field, there are some criteria by which your superiors judge whether your performance was good, bad or indifferent. Define those criteria and use them to prove that your performance was superior.

It is also possible to think in terms of how you helped others around you. You may explain such duties and responsibilities in your resume, which will help the reader understand why this was important and worthwhile work for your employer.

Outside interests and personal aptitudes may play a more important role in your strategy under these circumstances. Another way to counter this liability is to write about a variety of skills that you have acquired. Here, you could consider demonstrated aptitudes in: problem solving, analysis, persuasion, communication, etc.

Your interview strategy should be planned in advance. In addition to having a written presentation that will help you tell about yourself in a comfortable manner, you should rehearse the questions you will ask the employer. Refining your interviewing skills is particularly important when your achievements are difficult to quantify.

Think about answers to questions such as, "Why should anyone want to hire you?" "What can you offer that others can't?" Give reasons why you should be the employer's first choice.

4 You Have Relatively Few Personal Contacts

Each year thousands of people make job changes without relying on personal contacts. However, anyone can benefit from new personal contacts as a supplement to their job campaign efforts. You can do this by contacting appropriate "influential" people for just that purpose. This could include letters to prominent executives, authors of articles and books, government officials, bankers, lawyers, accountants, industrial development representatives, board members, prominent alumni and others.

Sometimes, lower level employees in companies of interest can be influential in helping you to get important introductions, or they may provide helpful information and insights.

You can broaden your circle of acquaintances by joining and becoming active in civic, social, industry, trade or professional associations. Under certain circumstances, you can maintain communication with other job seekers who are dealing with similar problems. You can help each other make appropriate new contacts.

Though the old boys' networks and the women's networks are playing a lesser role these days, they too can still be helpful. There are some that exist primarily to provide job changing assistance, such as "The 40 Plus Club" and many local women's groups do the same thing.

The quickest way to get to know "new" people is through confident and well-planned use of the phone. If personal contacts are really important to your job campaign, lay out a plan and start dialing. Ask for introductions to new people who may be willing to help you. This is a common technique in smaller occupational areas, such as advertising, journalism, public relations, accounting, law and specialized consulting. It can be applied in any field.

One of the most valuable talents you can acquire in building a successful career is the ability to build a base of influential contacts. The more successful you become at this, the higher you will be able to rise.

If it is timely, use a goal setting technique to expand your circle of personal contacts. For each new introduction you get, set two additional referrals as your objective. This will rapidly build your sphere of influentials and help your job campaign efforts.

You will find that if you are able to give people specific insights into the type of companies you are targeting, they are likely to be more helpful. Be sure to refer to your POISE database which will stimulate your thinking in that regard.

5 Your Earnings are Relatively Low

Many employers are quite happy to interview someone whose past earnings were low because they feel they can purchase that person's talents at bargain rates. From a practical point of view, however, low earnings will sometimes indicate to employers that the individual has low self-esteem or didn't achieve very much.

Whatever the truth in your situation, you will certainly gain nothing by bringing attention to your low pay. If it is brought up during discussions, be prepared to give examples of how you achieved, performed and contributed at a level well above average, or at least at a level equal to those who are more highly paid.

Sometimes you can turn this to your advantage by pointing out that you worked for the satisfaction of contributing, and were never inclined to boast or ask for a raise. As a result, you now prefer a work environment where you will be recognized for the value you produce.

More importantly, you will always have to be on the alert for employers who are out to get a bargain, when or if they learn that your earnings have been relatively low. If that happens, indicate that it has reached the point where you are confident that you can go out into the marketplace and sell your talents for considerably more than what you are being paid.

A common method to gain extra leverage is to time your change to coincide with a recent raise. This somewhat higher platform will add to your negotiating base, especially if you say that you expect your next increase to be even more significant. You will want to use that highest dollar amount as a basis for negotiating your next level of income.

When negotiating, be certain to probe to learn the compensation range. Many times, the top figure will be 1.5 times the base or more. Know what the upside potential could be. In early discussions about money, confirm that the hiring authority intends to match the compensation to the contribution. Virtually every employer will agree to that principle.

As you interview, note all of the employer needs, requirements, problems, opportunities, challenges or potentials. Relate your request for pay to the contributions you will be making in these areas. What you made before should have no bearing on what you can make in the future.

What you get should be your fair share of the benefits you produce for the employer. Based upon what you say about the things you have done, an employer places a bet on you that your future performance will be equally superior. Articulating your pertinent past accomplishments will help you maximize compensation.

6 You Haven't Been Frequently Promoted

It is quite possible for people to turn in years of satisfactory performance without receiving a promotion. Some companies are structured in a manner that does not allow for frequent promotions, and even above average performance is expected as a normal contribution. Sometimes, contributions are recognized with extra financial rewards; sometimes they are not.

If you are someone who has achieved substantial results without being rewarded by frequent promotions, then you may face some objections from potential employers who consider lack of promotions as an indication of few achievements or an inability to get along with others.

There are a number of things you can do to offset this. On your resume you should consider use of an achievement format. Here, you can get to the substance of what matters to the employer . . . your ability to produce results. The use of headlines in your resume can also be used to break your experience into segments which identify challenges where you acted successfully to reach an objective.

Some examples of such headlines would be: Successfully Introducing a New Product . . . Recruiting the Right Person For Each Job . . . Turning Around Unfavorable Public Opinion . . . etc.

There is another significant thing to keep in mind. Many very successful people use job changing as an opportunity to secure a promotion. They position themselves as being ready for the next step, but are unable to secure advancement with their current employer for no fault of their own. Naturally, you must justify your claim to readiness. However, more often than not, if you believe you are ready, others will agree.

If your infrequent promotions are brought up in the interview, you can point out that you focused on doing the job, and paid little attention to office politics. Where appropriate, show that your earnings increased steadily or that your job expanded significantly. This is often viewed as having more significance than titles, particularly if you are in a producer function.

In the future, you would be wise to work harder to communicate your contributions to your superiors. It is not always the best man or woman who wins the promotion. Often enough, the person who is politically sensitive gets the nod to move ahead.

Set goals. Lay out plans to achieve those goals. Utilize a system of realistic feedback from your boss and others to see how you are doing. The more you are respected and understood, the faster you will be promoted. Good communications with your peers and superiors is also essential.

7 You May Have Poor References

Many employers still do not check references, but you should certainly not risk losing an opportunity by making that assumption. When references are checked, people often lose opportunities because their references didn't convey a strong endorsement. To protect yourself, speak to each person who will serve as your reference, including your boss and his superior, if you have already left the company. Go over your resume and reinforce the positive aspects of your performance. Get them to agree, if possible.

The higher the position you are seeking, the more likely it is that references will be checked. (Also, the more likely it is that you've ruffled some feathers along the way.) Regardless of your level, if you have poor references, this can present a significant obstacle.

There are a number of steps that can be taken. Before you start interviewing, develop as many positive "new" references as possible. These could be past suppliers, customers, people who worked with you, or any influential person in past employer organizations who knew that you performed well. Purely social acquaintances are generally a last resort, unless you're relatively inexperienced.

Check questionable references to find out what is being said. Prepare other references to support your position and stress your positive assets.

Do not volunteer a questionable reference. You should only volunteer "positive" ones. If it is necessary to offset bad references, try to develop "status" references. These are prominent people in your field or company, or those in public life: presidents, vice presidents, directors, board members, authors, senators, congressmen, mayors, etc.

If the bad reference is a past boss, try to defuse the negative by explaining that differences of opinion existed. Keep your explanation objective and unemotional. Do not imply any negatives.

If necessary, you may have to confront the negative references and advise them that their input is keeping you from winning a new position . . . making it impossible to support yourself. If this does not result in at least a neutral statement, then you may have to imply you will have to seek a legal remedy. In that case, you may consult a lawyer for advice on what actions can be taken, or confer with the company's personnel officer, who may intercede.

Most employers today are aware of the legal consequences of providing a bad reference, and they will tend to cooperate with you. Also, the passing of time can tend to mellow harsh feelings.

8 You Were Terminated From a Previous Position or Positions

Some people seem to feel that if they have ever been terminated, they must communicate this on their resume in order to be fair. Worse yet, they believe it is a stigma on their career that must be carried forever. This is simply not true.

Naturally, anyone reading a resume that indicated a person was fired would want to know why. They may very well assume the worst and decide not to call, even though the problem may have been due to a decline in the company's business. In such a case, the potential employee is actually misleading the potential employer by giving only half the story . . . the negative part. Better to leave it off entirely, saving any necessary detail for the interview, where it can be carefully explained.

Also, if appropriate, you can indicate that frequent job changing is common in the industry in which you have been employed. Explain that you were recruited from one position to the next by people who were aware of your superior performance in each prior job.

During the interview itself, the same principles would apply as for the unemployed person. If it is brought up as a concern, a truthful statement that the termination was due to factors beyond your control and not related to performance, would surely suffice. You want to have examples ready which demonstrate that you are a contributor and an achiever. When possible, you should also make clear that you left each employer on good terms.

When explaining a termination, it is your responsibility to sell your credentials in the most positive manner, up to your maximum potential. It is the "buyer's" responsibility to determine if there is a better candidate. References usually will not hinder your efforts to win new employment.

Negative information about your termination usually will become known only if you reveal it. Never provide any information that might harm your cause. Whatever deficiencies your former employer perceived, there have to be positive contributions you made to offset those negatives. Focus solely on the positives.

Margin for error grows smaller each time you are terminated. If you have been fired more than twice in recent years, it's time to take stock of yourself and probably seek out some entirely new directions. In the event you think you need special professional help, do not hesitate to seek it. The flip side of the coin is generally reassuring. Most terminations are not traceable to bad work habits or lack of employee contribution. Employers are generally aware of this.

9 You Have No Experience in Large Corporations

Many people build excellent careers in small and medium-sized companies without ever working for a large corporation. Often they are more versatile and have had the chance to take on more responsibility than would ever have been possible for them in a large corporation. Nevertheless, when such people apply for positions in large companies, they will sometimes encounter resistance because they lack blue-chip or major company experience.

Fortunately, common sense is on the side of the job seeker. It's easy to realize that the only logical objections a potential employer might have are: (1) you would not function well in a complex environment; (2) you don't know how to get cooperation from people at a variety of levels; (3) you are simply not used to dealing with large numbers of people.

The fact is, the typical immediate work unit in a large corporation is the same size as one in a smaller company. Not only that, the person in the smaller company might have achieved a higher level of responsibility with broader experience than his counterparts in a large company. They may, therefore, be even better qualified to function in a sophisticated environment and to get cooperation at various levels.

Sell your ability to contribute an entrepreneurial flair, your multifaceted experience and your capacity to extract more from available resources. Promote yourself as someone who will produce results.

Before joining a larger company, you should realize that the long standing value of being associated with a Fortune 1000 or "Blue Chip" company is being questioned more and more. The consensus now is that you should profile your own personality against that of any potential employer before deciding what's right for you and your career.

Some large companies are fast-moving and some small companies are slow-moving. There is no pat answer to the large vs. small company question. Don't be quick to pick your next employer based on size alone. Nevertheless, when you lack large company experience, but wish to explore opportunities in one, be sure you interview the company while allowing them to interview you.

Look for employers where there is experience-building action taking place. Favor situations where there is growth, new technology, new products or services, or even a turnaround effort. Avoid stagnant or declining situations. Place yourself where you are gaining "hands on" experience solving tomorrow's problems today. The COMPASS and POISE databases will prove helpful in that regard, because they are both indicators of those types of activities.

10 You Need to Maintain Confidentiality

Many people overestimate the need for confidentiality, but ultimately, this decision should only be made by the job seeker. The problem with maintaining absolute confidentiality is that it tends to make your job search efforts less productive.

It is important to keep in mind that, no matter how many steps you may take to keep your activities confidential, there is always the chance that they may be communicated to your employer. Nevertheless, it is possible to run an active job search and still minimize the possibility in a number of ways.

One traditional method is to use the third-party approach in contacting potential employers. This simply means that a friend or associate writes a letter to potential employers for you without mentioning your name and without giving facts that would identify who you are. In some cases, for a highly visible executive, this could mean slightly modifying the facts to keep your identity anonymous.

A second approach is to state in letters and on your resume that your communication and activity is strictly confidential. Sometimes people have simply stamped their resume "Confidential." This covers most situations. A stronger notice would be: "Effective care to protect the confidentiality of this communication is essential. Thank you."

In general, you would either avoid blind ads or use a third-party approach when responding to them. During the interview, reinforce the fact that your meeting must remain in strict confidence, because you would either be embarrassed or lose your present job, if your activity were known.

You should also be prepared in the unlikely event that your employer finds out about your efforts. Your response when confronted might be: "I test the market every three or four years. So far I've never found anything better than what I have." "Don't you think that's a sensible way to run a career?"

Many employers will not expect such a reply and be taken off guard. They may well agree that it is indeed a sensible thing to do and forget the matter. For employers who take a more aggressive view, you may want to remind them of your legal rights. Today, managers are usually cautious about how they handle termination. If things get testy, seek out your company personnel officer, who will usually try to calm down the situation.

If exploring new situations places you under severe risk of termination . . . one approach is to get a large amount of communication ready and put it out to the market at one time. Then, arrange interviews so they occur in a short period of time.

11 You are Attempting to Switch from a Military to a Civilian Career

Each year thousands of highly capable individuals leave the military. Often they have held responsibility for complex operations involving many people and substantial resources. They have had to meet objectives, on time and within budget. In many cases, they have developed superior management skills and built a record of achievement.

Nevertheless, when people leaving the military attempt to market their talents in the private sector, some potential employers will be skeptical. The reason most often given by employers is that military personnel have difficulty performing in an environment where a profit is expected. Employers may feel you are not accustomed to the pressures.

Overcome this by giving examples of cost reduction, productivity improvements and efficiency gains you achieved. Show how you extracted a maximum return from each available dollar, man-hour or investment in equipment and facilities.

The truth is, many officers have performed under conditions more demanding than those in private-sector companies. That doesn't change the realities of perception. It seems that many hiring officials simply have difficulty picturing a military officer working effectively in a private company.

If you are attempting to find a position in the private sector, you will need to take the initiative in order to change negative perceptions. The first step for you is to get rid of your own bias. Private sector employers are a lot more like your military employer than you realize. They want to get things done on time, correctly, and consistently "meet the objective." Sound familiar? Well, if it does – and it better –keep looking for more things in common as you learn about the world of private enterprise.

On your resume, you should use a format which places your achievements and experience under clearly defined functions which relate as much as possible to those required in the private sector. You can even go so far as to indicate that your experience was equivalent to that of a person who holds a particular title in the private sector, such as Distribution Manager, Chief Operating Officer, Director of Telecommunications, Personnel Officer, etc.

Junior officers should maintain a degree of flexibility. Many doors will open with relatively little effort. Field grade personnel are the equivalent of industry's middle managers. More thinking and effort is called for when you have achieved these ranks. Those of you who have been fortunate enough to achieve General Officer status will find you are received with great respect.

Regardless of this good news, you are going to have to select career and industry direction in advance. Few employers will accept the responsibility of doing that for you. They simply will not take the time to figure out who you are and where you fit. You must provide a clear statement of what you want to be, and it must equate to common private sector positions. Study the COMPASS database carefully to make sure you fit into a commonly recognized job category.

Generally, you should follow the principle of selling your skills as a pragmatic leader -- who gets results under demanding conditions. Essentially, avoid defining your talents too narrowly when attempting to appeal to business employers.

12 You Worked For a Company Which Performed Poorly

Just as it is possible to enjoy some of the positive rub off which comes from being part of a highly respected company, it is also possible to suffer from the negative image of a company which failed or has a poor reputation. The important thing for you to remember here is that you developed skills and made contributions which indicate an ability to contribute to a potential employer.

On the resume, therefore, you should be sure to separate your achievements from the overall results of the company. There is no need to write about negatives which have nothing to do with your ability to contribute. Know when to "stop telling the story." Talk only about results in those areas over which you had control.

If the subject is brought up in the interview, you might explain that the overall results were due to forces far beyond your control. You can go further, though, and turn this potential liability into an asset by adding that it was an interesting learning experience, and that you are a better manager as a result of being "successful in a failing environment."

Develop achievement examples which demonstrate how you prevented the employer's situation from becoming worse. Your work may have enabled the organization to survive for a far longer period. Successes in your area of responsibility which offset damage occurring elsewhere in the organization can be important. Sell yourself as a person who was part of the solution rather than part of the problem.

The strategy will work best when you are coming from a declining or low-profit industry. The important thing to remember is, when you are leaving a company with a poor track record, be sure you don't take the blame for its failures.

13 You May be too Old

It's always quite interesting to listen to the opinions which people express on age barriers and job hunting. In job seeking, older age can certainly prove to be a negative. However, it is quite unfortunate that so many unhappily employed people believe they are too old to change jobs.

Even though they may not consciously realize it, the truth is that many use age as a convenient excuse. Most of the time they either lack the confidence to try, don't know how to go about it, or are not willing to go through the work.

At a senior age, winning a new job is never a simple task. However, despite difficulties in adjustment, a good job change can bring you a totally new feeling about life. The excitement of new work, a new location, and new associates may provide you with a mental stimulation that helps you look and feel ten years younger.

In the 1970's, the job market seemed to be placing an ever-increasing emphasis on youth. However, in recent years there has been a definite shift toward the favoring of experience over youth. If you happen to be one of the people who thinks he is too senior in age, you might reflect on this briefly.

At the same time, appreciate that you have accumulated experience which could be of value to literally thousands of firms. Your major concern should not involve whether or not to seek a job. The key question is simply how and what to communicate to the right people in the right companies.

What does being too old really mean? In the United States half the population is over 31. To some people, being too old is surpassing this number. Being over 40, or 50, or even over 60 is far from being an insurmountable negative. To be sure, as you get older, job hunting will become more difficult, and particularly so in certain fields and industries.

However, age problems in job hunting are relative. Being too young could mean that you're 45 and shooting for a top spot in an industry where 90% of the top executives are 10 years your senior. On the other hand, being 32 could be too old in the advertising field if you're not yet a Vice President.

Age really becomes a barrier at that point when you mentally accept it as an obstacle. To be effective, your focus should not be on chronological history, but on the problems you have faced and solutions which came about through your efforts. You should have very little difficulty finding a way to persuasively state some accomplishments which imply . . . "I can do the same thing or more for you."

In most cases you will have to rely more on letters than resumes, since letters can be more easily slanted to cover your age, length of experience and dates. You will find it useful to make a point of stressing your sound business judgment, your ability to work in any type of environment (with all levels of management), and your drive (which is, of course, what many believe senior people do not possess).

Sell your maturity and depth of experience. It may be appropriate to enroll in a college course to show that you perceive yourself as continuing to advance in your career. Select a subject which will seem timely, whether it reflects a business or personal interest.

As far as your resume is concerned, you may wish to avoid mentioning your age. As a general rule, emphasize only recent work experience (the last 10 years). You can, if appropriate, disclose your age during the interview.

As you become older, your need to make a good first impression will become even more vital. If you're out of shape and run-down, start exercising under a doctor's direction. Make sure your appearance and dress are at their best. Avoid dated clothing styles. Invest in higher quality and better tailored garments which are appropriate for the level of income you are seeking. It is important to project self-confidence and a positive attitude.

14 You Haven't Shown Much Leadership

People with leadership capabilities usually don't get the opportunity to exercise them early in their career. Also, many think of leadership as the dramatic, visible force that they have seen depicted in movies. The truth is, leadership is exercised in many ways, and most of us have exhibited leadership qualities more often than we realize.

If you have consistently met personal goals, have built loyalty in those who work for or with you, or have helped others in a meaningful way, then you have probably demonstrated some leadership qualities. If you consider yourself a leader, then claim leadership abilities as one of your strengths. You can indicate that you lead by example, and that you are a motivator. Of course, maintain the appropriate degree of humility if you are just starting out. Good leaders try not to brag.

When questioned about your views regarding leadership, explain that it takes many forms. Then break the key leadership qualities into component parts which relate directly to strengths that you possess, such as . . . someone who reaches goals, an individual who makes people feel good about themselves, a person who finds solutions to tough problems, one who exceeds existing standards, etc.

19 Your Experience is Limited to One Company

The problems of staying too long in one job are similar to staying too long in one company, and so are the solutions. The concern on the part of a potential employer would be that perhaps you have lost your ability to adapt to different environments and would therefore be less effective.

The answer is for you to show your adaptability by playing up your ability to manage and deal with change. Have you changed departments? Were you transferred on occasion? Did you serve in different divisions? Have you had a number of bosses? Do you know more than one product line? All of this information can be important in positioning yourself in a more positive fashion.

You can take the initiative by pointing out that, at various times, your responsibilites actually fit quite distinct job titles. The COMPASS database will prove helpful here. It is an accurate reflection not only of the specific jobs available today, but also of the requirements for them.

Sometimes the very nature of the company's growth, expansion and diversification can help you project an image as a versatile perfomer.

Communicate how you have helped your employer increase revenues, profits, assets, market share, etc. Take partial credit for the winning moves of the team you were on. Few things are accomplished by one individual. Teamwork is what produces results. If you were there, you earned the right to claim participation in delivering beneficial results.

When a company has undergone significant changes during your time there, this should be emphasized in your oral and written communications. You can then think in terms of, "We achieved this goal, acquired that company, started this business, etc." even if you were not personally responsible for those actions.

Also, remember that there are lots of positives to working for one company for a long time; not the least of which is that you are loyal, stable, and will not skip from company to company.

A long tenure with one employer constitutes strong evidence that you have been both effective and compatible. You can share your pride in your staying power and a long record of contributions. As always, a positive mental attitude will play an important role in dealing with this liability successfully.

20 You Have Made Lateral Job Shifts

Most careers are not planned. In fact, for many people, their careers "just happen to them." Sometimes this means they move from job to job, either in the same company or with different employers, without gaining any appreciable increase in authority or responsibility.

If that has happened to you, and you are now determined to make a major step forward, you should understand that some potential employers may view your lateral job shifts as indicating a lack of either ambition or talent. Fortunately, there are a number of steps you can take to deal with the problem.

You can start on the resume, by putting more emphasis on what you were able to contribute overall, and making the progression of job responsibilities secondary. You should also consider placing more emphasis on your most recent job. This is consistent with most employers' desire to know "what you've done lately." By summarizing the earlier jobs briefly, your most recent position will (graphically) take on more significance. Attempt to portray the jobs as a planned progression.

Before you begin interviewing, you should examine why you have made lateral job shifts rather than progressing up the ladder. You will probably find that you were not in the habit of setting (proper) goals and objectives for yourself. Furthermore, there is some likelihood that you did not think seriously about your career and job hunting plans until now. Remember that it is never too late to start moving upward.

In the interview itself, point out that it is important for you to find a company that wants superior performance and is willing to promote accordingly. You may have to admit, at some point, that you have worked more for the satisfaction of working rather than the challenge of career advancement. But now you are determined to make new contributions on a higher level. This should be in an environment where the opportunities are well matched to your ability to deliver results.

Be careful however! Aggressive interviewers may show a tendency to take advantage of you by offering less money or holding back title. Don't be talked out of your determination to get ahead because you are over-anxious to begin with your next opportunity. You may have to work a bit harder on your negotiating skills, but it will be worth it!

21 Your Actions Have Not Realized Positive Results

Occasionally, people have performed well, but the results of their actions will not be realized until some future time. Here they can find themselves in the awkward position of having nothing to claim in terms of concrete results from their efforts.

If you find yourself in that situation, you should use anticipated results based on plans, forecasts or expectations. For example, you can make the statement that sales and earnings are "projected" at record levels, or that XYZ Company "expects" its new product to gain a 20% market share.

In other words, you can point to future earnings and market positions as a result of your actions. The fact that you are leaving the position somewhat ahead of the end results, should not take away from the recognition that your actions have been vital to that future accomplishment.

To reinforce your claim, examine your earlier contributions. Look for as many specific result indications as possible. This will reassure the prospective employer of your ability to deliver. Employers want to be convinced, and you should be prepared to give as much evidence as needed. From an employer's point of view, the important thing is whether you can take actions that get results. Results statements, properly supported, can sell you into your next position.

22 You Have Responsibility in an Area Where a Direct Competitor is more Successful

Sometimes it is possible to do a good job, achieve more than is expected, and still come out second best against a well-managed, aggressive competitor. If this has happened to you, follow the principle of communicating your achievements without regard to what competitors achieved. On the resume do not offer information that would indicate the competitor was more successful.

As part of your discussion about a successful competitor, you should acknowledge that they were indeed successful, but you should then point out the following . . . (1) you learned a lot from the encounter . . . (2) the competitor did some very smart things, which you would do for your next employer . . . (3) you now bring exceptional value to your next employer, because you are a more "seasoned" competitor.

This is not a serious liability unless adverse publicity has surrounded the situation. If that is the case, it is more likely you will have to change industries. That could become an advantage if the competition in your new field is not quite so sharp.

23 You Need More Writing Experience

There are relatively few positions where writing will be an important criterion. Where it is, however, lack of writing experience or failure to have been published can be a significant liability. One of the ways to overcome this is to use a narrative style in your resume, and make sure your resume is an example of superior writing.

In addition, you can write speculative material of the type that would be required for the desired position. For example, you might decide to create speculative ads for an advertising agency, speeches for a public relations position, technical material for a technical writer's spot, etc. You can write a paper that could become an article in a trade magazine, or promotional material which a potential employer might consider helpful.

In some cases, people have even written small brochures on a specific subject and had it typeset and printed. They give the brochure a title and list themselves as author, including a summary of their credentials and a photograph. Presenting your material in this format helps to lend authority to your story and enhances your image.

You can also consider meeting with editors and publishers to discuss articles that you could write for them. Some may express interest in having you do this. If that is the case, do not hesitate to mention in interviews that you have recently spoken to editors and publishers about writing specific articles for their publications.

24 You Didn't Hold Many Jobs in College

Some employers look for evidence of extensive part-time and summer work on the part of candidates who have recently graduated from college. If you didn't hold many jobs while in college, there may be numerous good reasons you can cite: a heavy course load, superior grades, sports participation or even above average social activities.

You can also stress travel or special projects in which you were involved, as well as personal characteristics which might be important on the job.

In fact, you may not have distinguished yourself in any particular way during your college years. In that event, good planning and interview rehearsal will be important for you. Be sure to decide upon career and industry options ahead of time. With your plan completed, learn as much as you can about new areas of interest to set yourself apart from others in a similar situation.

25 Your Experience is in an Industry Different from those you are Targeting

With the decline of many smokestack industries and the loss of middle management jobs in many others, lots of hard-working, well-qualified people find themselves forced to look for employment in industries where they have absolutely no experience.

The obvious concern of an employer is that your lack of knowledge will keep you from performing as well as someone who "knows the industry." Frankly, this is a more serious problem than most job hunters realize. In other words, you have a "credibility gap," and it is up to you to close it. Fortunately, there are a number of ways this can be done.

You can begin with your resume. Structure it so that the employer can see parallels between the functions they need and the functions in which you have experience. Point out that you learn quickly. Show achievements in as many product lines and markets as possible. Give evidence that you can come into a new situation and learn quickly enough to contribute in short order. Use examples of how you frequently succeeded in new areas.

One of the best ways to deal with this liability is to decide on the industries that interest you the most . . . and learn as much as you can about specifics in that field. The most common method is reading trade publications. Annual reports, along with 10-K reports which companies furnish to the Securities and Exchange Commission, can also be very informative.

If you are seeking higher income or want to maximize your credibility, you should consider going further. An excellent approach in this situation is to use the phone to set up field interviews with persons already in the industry of interest.

You will find people surprisingly receptive if you tell them what you are doing and why. It is amazing how much you can learn in a week.

You can also prepare a research paper on issues and trends affecting the industry of interest. This shows you had the determination to get that knowledge on your own initiative. The very act of conducting this research will set you apart from other candidates who do not have any industry knowledge.

Of course, it will help if you can target on industries that have some characteristics similar to those in which you have experience. Point out any similarities in terms of markets, distribution processes, products, manufacturing equipment and processes, raw materials, or any other factors.

No matter what approach you decide upon, put at the top of your agenda the objective of learning as much as possible about new areas of interest. You will quickly gain a significant competitive advantage!

26 You are an Entrepreneur Seeking a Corporate Position

When you consider the thousands of mergers and acquisitions that have occurred in the past 20 years, you realize that a large number of successful managers were once entrepreneurs.

Nevertheless, many employers will be hesitant to hire someone who has been running his own business. The concern is that the entrepreneur, accustomed to having things his own way, may not be a good team player and will not accept the limitations of corporate structure.

There is also a "Catch-22" here that you must be aware of. Companies often put out the word that they are committed to an entrepreneurial style of management. However, when they come face-to-face with a real entrepreneur, they will back down. Understanding this will help you to overcome the traditional resistance you may meet in the marketplace.

The best thing for you to do first is to practice some humility. Remember, job hunting puts you in the role of the seller, and you are used to giving orders and having them followed.

Secondly, the buyer (your next employer) has to become convinced that you are going to help him "get results," "succeed" and "look good." He doesn't want somebody who will try to outdo or outsmart him.

There are a number of ways for you to deal with your situation. On the resume, it might help to emphasize examples of teamwork and functional strengths. This makes it easier for potential employers to think of you in terms of how you can help, rather than in terms of why you won't fit in.

The entrepreneur, so widely heralded as a role model in business, is also one of the most misunderstood. Many employers subconsciously resent the "free spirit" image of the independent businessman.

One good way to counter this perception is to communicate your belief in professional management practices and human values, to balance the tough guy "results" orientation you are expected to possess.

Market your ability to innovate and extract maximum value from every available dollar, manhour or investment. Explain how you have learned to make and keep dollars, and how you expect to do the same for your next employer.

If you are being considered for a position listed in COMPASS, be sure to show point-for-point that you meet all the criteria, including those which relate to motivation, teamwork, leadership and other personal relations factors.

27 Your Previous Earnings Were Too High

On the surface, this may not appear to be a difficult problem. However, if you have personally maintained very high earnings, it can be difficult to uncover comparable opportunities. There are many reasons why this kind of situation can occur. When considering corrective action, each situation should be viewed individually.

For those who were fortunate to achieve high earnings in the producer role, such as stockbroker, sales executive, lawyer, public accountant, etc., the firm or product line you affiliate with will have a lot to do with your ability to duplicate your prior record.

One way to protect yourself against disappointment is to ask to meet with other members of the organization who are filling similar roles. Often they will be candid about the advantages and disadvantages you'll face in that company.

Those who have had their own business and seek to join a company as an employee will find it difficult, if not impossible, to immediately equal their prior income. The best strategy in these situations is to play down your earlier title and independence, while emphasizing your ability as a team player. Naturally, your capacity to build revenue, enhance profits, or solve problems will be very important.

For those very successful people who are less concerned with money, but who want a second career, a different approach will be called for. For example, a company president who seeks nonprofit work for personal reasons will want to emphasize such things as the need to devote full-time energy to a new and worthwhile cause (an ability to raise money, a long-standing interest in the activity, etc.).

Of course, there are those who have experienced higher earnings as a result of extremely hard work, who no longer wish to put forth that intense effort. To overcome this, you will want to communicate understandable reasons for your decision.

This could include a need for more time with your family, a long-planned opportunity to pursue certain outside interests, or the need for a new, more balanced life-style. Employers are always skeptical of anyone who is prepared to take a financial step down.

The vision of future benefits to the employer will determine the potential compensation. What you say about your past accomplishments will be the indicator of your potential to deliver results. Another way to maximize income is to suggest an incentive or bonus compensation package. Base your negotiations on your ability to produce results.

28 You Have Poor Titles Which Don't Reflect Your Responsibilities

This is not a serious liability because it is easy enough for most people to distinguish between the "substance" and the "form." Therefore, the basic strategy you want to follow is to de-emphasize the titles, and stress the substance of your achievements.

Let's look at some specific problems. If you had no official title, but functioned as manager, it is appropriate to claim this as fact. Some large corporations intentionally de-emphasize the importance of titles.

You may be called "Project Administrator." This implies a narrow scope of responsibilities to some employers. In this situation, your actual job could be the equivalent of a Division General Manager with multimillion-dollar profit responsibility. Be sure to communicate that in understandable terms.

The message is, don't sell yourself short. Don't use titles on a resume unless they help to promote you. If your title doesn't help to communicate your role in a positive way, use a headline or even a sentence to relate the breadth, depth and scope of your responsibility.

Be sure to communicate who you really are, regardless of title. The significance of a title may not be well understood from one organization to another. It is even more confusing when you are going from government or education into business.

One very convincing way to demonstrate the true level of your job is to show a number of examples where your responsibilities are described under advertised openings which carry a more senior title. COMPASS would no doubt contain many examples you could use.

Of course, you should be honest in what you communicate, but it is acceptable practice today to restate an official title into general, more understandable terms.

An "Assistant Controller" can refer to himself as a "Financial Manager," if that is common terminology for the same work in a new industry. A salesman who has done extensive recruiting and training of other salesmen can legitimately claim that he has functioned in a sales management capacity.

The problem becomes more difficult when you are changing careers. However, the same principles apply. The School Superintendent has broad managerial responsibilities for personnel, facilities and budgets. Government employees must translate their story into completely different terminology.

In these situations, be sure to emphasize functions, and perhaps do not use formal titles at all. If you want to make the transition, you will have to adopt a new vocabulary and maybe even some new ways.

29 You are an Educator Attempting to Switch to the Corporate Sector

Thousands of educators have either been forced out or have chosen to leave their field and find new positions in the private sector. Once they begin their search, they can expect to encounter some resistance from employers who assume they have little or no knowledge of their industry and few skills that could be applied in their company.

The truth is that many educators are superb administrators and proven managers. Some are excellent trainers or public speakers. Many of them are creative, strong leaders, or have successful experience in community affairs. There are also those who have specialized skills in science, mathematics, visual arts, or even the trades.

Most educators are excellent communicators, trainers and motivators. They have high intelligence and understand how to learn. They have strengths in community and public relations, interpersonal relations, administration, regulatory compliance and other areas pertinent to new career fields.

If you are an educator attempting to switch to the private sector, you should show achievements in a variety of functional and skill areas. Check COMPASS to learn the skills commonly required for the type of position you seek.

Also, since you know that lack of industry knowledge will be a concern, take the initiative to learn something about an industry you are pursuing. Learn about its opportunities, problems, issues and trends. Review POISE for growth companies in the industry in your area.

If you are pursuing a particular function, such as sales distribution, manufacturing or purchasing, you should learn as much as possible about it through reading, seminars if time permits, and discussions with people in that occupation.

Target your job search to fast growth and emerging industries. There aren't enough people available from their industries to meet the needs of these growing organizations. They have to grow their own staffs. What better raw material than former teachers?

Though you should not underestimate the challenge you face in transferring your skills, more and more employers have developed favorable attitudes toward educators. Those before you have done a good job of selling the positive characteristics associated with this occupation.

Please note! In spite of this advantage, you will have specific responsibilities if you are to capitalize on these favorable perceptions. You must have your objectives defined before you begin your campaign. No employer wants to do this for you.

Teachers should cite their ability to generate tangible results. Show successes through increased test scores, favorable college admissions rates, waiting lists for classes, or increased budgets because the community wants more of what they can do.

Perhaps more than any other group, teachers and educators have succeeded in adapting to new work environments. There appear to be a number of reasons for this.

Most important may be their understanding of money economics. The dollar restrictions in the educational environment are clearly set. In industry, it is possible to get ahead financially at a much greater rate through hard work and discipline.

30 You Were Terminated by the Person Who Got the Promotion You Wanted

Most corporations have a pyramid structure in which the achievers keep getting promoted to higher positions. But, at each succeedingly higher position there are far fewer opportunities.

This means that, at various levels, two well qualified people will be vying for the same job. When one wins, the other is usually best advised to seek advancement in another part of the company, or to search for a new position.

Often, the person who received the promotion is anxious to have the "competitor" leave. They may even take some satisfaction in terminating that person.

If that has happened to you, it could be a serious liability. Outsiders may feel that your termination indicates a lack of achievement, is a permanent setback, or signals an inability to get along well with people.

In offsetting this liability, you should not make it obvious that you were terminated. You will have to concentrate on all the positives that led to your being a serious contender for the promotion in the first place.

More importantly, don't imply any bitterness about what happened when the subject comes up. Discuss the situation in a totally objective, nonemotional way and move the conversation along to the next topic.

Point out that what happened to you could happen to any other top performer. Remind the employer, when there are two good people available, only one can be selected.

When the winner's first action is to fire the person who was a candidate for advancement, he probably thought that person was also too capable or posed a threat of some sort. It shows that the rival still fears comparison of his results to yours.

31 You Have a Short Work History With Relatively Few Achievements

This situation is often faced by young people who have not had the opportunity to achieve very much. The problem is that you may be in competition with others who have achieved more. It's easy to get concerned in such a situation, but it's possible to overcome this problem with a few imaginative steps.

You can start on the resume by showing a range of activities which convey that you have worthwhile experience, knowledge or potential. Also, you can relate drive, enthusiasm, attitude and cultural interests. These can enhance your overall impression.

In addition to experience, knowledge and accomplishments, companies hire the person. It is widely known that some employers base hiring decisions on appearance, self-confidence, writing skills, your ability to articulate a problem or solution, etc. In fact, good personal chemistry still accounts for a major portion of all hiring decisions.

Many young people with a short work history can write a brief paper on a field in which they have an interest. They are quite capable of doing the required research. By sending that paper, along with a cover letter, you can divert the employer's attention from examining your past. This leaves you free to focus on the company's future.

You might be able to cite term papers or reports you produced at college to demonstrate your wide range of interests. You could highlight your ability to conduct research, to rapidly absorb new knowledge, to analyze information, etc. A trip to Europe may have given you valuable exposure, fresh insights, and appreciation for the different means by which others accomplish results.

When you are short on apparent achievements, you can also look to focus on attitudes and values that are important to employers: "My attitude toward hard work is influenced by family tradition: part-time job during 3 high school years, paid 50% of my college expense through outside employment, studied and attended class 12 hours per day, etc." These examples suggest that you have the ingredients of becoming a high achiever early in your career.

32 You Don't Have Enough Line Experience

Most management positions require a background in which a person has worked his way up the "line," learning to handle responsibility for people, departments, functions or operations within the business. Sometimes, however, even the most capable people are asked to fill "staff" positions, where their talents are often leveraged over an entire organization. When this happens, these individuals build a record of achievement without acquiring "line" experience required for many attractive positions.

If you have the "staff" label, you may find that employers will have reservations about your ability to lead and manage. There are a number of steps you can take to minimize this potential negative.

On the resume, don't make this problem obvious by emphasizing titles. You will probably want to use a situational, functional or achievement format. When it comes to communicating, you will want to write and speak about tangible impact areas regarding revenue, profits, growth, etc., and indicate the scope of your efforts.

For example: specify the number of people who were impacted by your work. Recognize that your staff work had a major influence on the bottom line, and the total organization. You can also convey strong leadership qualities and characteristics associated with "line" managers.

33 Your Education is Unrelated to Your Goals or is Insufficient

If you've been working any significant length of time, you already know that your formal education has less and less to do with your marketability as time goes by. Yet a quick scan of COMPASS will reveal that many corporations, especially the larger ones, have set up rigid criteria for minimum education requirements for each job.

One thing is certain. It is foolish to lie about your education. On the other hand, there is no need to make it obvious that you have an education which is unrelated or insufficient for your goals. If you have achieved results (outperforming others with more extensive education), then you should focus heavily on communicating past achievements which suggest future benefits, rather than educational history.

Unfortunately, a lack of required education can be a liability that will not be overcome through use of words and positive attitudes. If you anticipate a permanent obstacle that will stand between you and your goals, you may have only one solution. You may need a new degree, or specific courses to deal with the problem.

If that's the case, map out your plan and follow through with it on a step-by-step basis. Get enrolled immediately to give potential employers a strong signal that you will soon possess the credentials they want. Take courses that complement your on-the-job experience, and which qualify you for higher responsibility in the future.

Of course, if your initial contact with an employer is through a letter that focuses on specific areas of potential contribution, then education may never become a question. Also, you can state your intention to acquire additional education required by the job in question. Further intentions have been the basis for many successful employee relationships.

34 You Need to Change Careers

Many individuals who are concerned about changing employers will also be facing the special job hunting problems associated with career change.

Because their interests and life-styles have shifted, more talented people than ever are successfully changing careers. Many ambitious individuals have found themselves in overcrowded specialty areas with diminishing opportunities. For example, successful moves out of education, government and heavy industry have become increasingly common.

Those who need to change careers will find it helpful to identify functional capabilities, along with skills, knowledge and traits which should be emphasized.

The major obstacle they will encounter however, is a lack of specific industry experience. There are a number of simple steps that can be taken to offset this problem.

Younger job hunters can state their strong interest in an industry to compensate for a lack of experience. Those making a more significant change face a greater challenge. They may want to learn about a new field by reading trade publications and other pertinent published information.

Trade magazine articles contain news items which give you clues about problems and opportunities facing a particular firm or industry. This information enables you to demonstrate knowledge which can help you make a good impression. Reading the basic text for a college course or even a college outline review manual can help you to quickly master the common terminology of a new field.

Of course, one of the fastest ways to learn about specific companies that are growing rapidly and are most likely faced with having to recruit outside their own industry is to study POISE for your geographic area.

It is surprising how quickly you can acquire knowledge of industries, people, products, markets and companies through reading. The more conversant you can be with an employer's problems and opportunities, the more they will be interested in you.

Obviously, when you are seeking work in an entirely new field, the job changing process is considerably more difficult. Your creative material must highlight those skills and facets of your experience which would be valuable in the new field.

In your written communications, break down your experience into functions and skills common to those in the fields you wish to investigate. The key is to do this while not over-identifying with your present career field.

During interviews, your focus should be on showing the employer how transferable your skills are to his operations. As always, enthusiasm for the new career field is vital. Present examples of how you have faced change before, learned rapidly and produced superior results.

When you are attempting a career change, letters will often prove far more productive than resumes. You should also be open-minded about smaller growth companies. Demand for talent often exceeds the supply in these situations.

Franchise and business opportunities can also prove attractive for career changers who have the capital to invest. Today, there are many men and women who found their way to greater prosperity and independence by making such an investment.

35 Your Academic Record Was Mediocre

As you build experience and a record of achievements, your academic record becomes less important. For many young people who have only recently graduated from college, however, it remains one important indicator of their potential. If your academic record was mediocre, therefore, you may face resistance from some employers.

It is well to remember that there are two basic reasons for a mediocre academic career. One is that the course material was extremely difficult. A demanding curriculum in a school with high standards can result in an intelligent, hard-working student achieving a C average. From one perspective, this may appear to be a liability. Actually, just completing a difficult curriculum is a fine accomplishment.

The second major reason is that the student did not apply himself fully to the academic program. Psychological and emotional factors change, however, so that someone can become well motivated a short time later or in a new work environment.

If your grades were below average, do not mention this on your resume. Emphasize any work experience and coursework that relates to the position you are seeking, along with extracurricular activities. Make a careful assessment of your best qualities and selling points. This is not a time to underrate yourself.

Remember, employers don't hire grades, they hire people. Many successful leaders didn't hit their stride until after graduation. When you have little that is positive to say about your college academic experiences, steer your written and oral communications to other subjects, including future events and aspirations.

36 You Are Unemployed

This is perhaps the most feared of all liabilities, but this certainly need not be the case. If you've just been fired or otherwise dehired, the first thing to remember is not to panic. If you do, you are going to lose confidence and your ability to think clearly. Being unemployed today is not an uncommon condition. More than one in four Americans will successfully overcome the problem of unemployment during their lifetimes.

People may not admit it, but it is likely that many executives who interview you will have been unemployed themselves. It is a rare individual who can succeed in moving ahead without quitting or being fired, (or at least encounter the threat), during his career.

Quitting or being fired doesn't imply failure in the eyes of everyone else, even though you may feel depressed. Don't let it give you a guilt complex, and even more important, don't feel sorry for yourself. Most of the time people quit or get fired because of a personality conflict, or because someone higher up demands a change due to pressures at that level. Other common reasons for terminations include cost reductions and acquisitions.

The first reason we mentioned is the most significant. This concerns those situations where people could not get along with their boss, or at least not the way the boss wanted! There is a lot of truth in the saying . . . "choosing the right job is largely a matter of choosing the right boss."

Being unemployed does mean that you'll often be carrying a handicap. Regardless of the circumstances, the great majority of firms prefer candidates who are presently employed. Nevertheless, every day people turn bad situations into greater successes. Your ability to bounce back after a bad experience will be a true test of your basic strength and determination.

Register for unemployment. Don't let your pride stand in the way of accepting a weekly unemployment check. Almost everyone who loses a job ends up being unemployed for much longer than they expected. Another important step is to get a resume prepared immediately. The resume should look as though you prepared it before your termination and should not reveal that your employment has ended.

You will also have to be ready for some disappointment. Being an unemployed person means you will encounter false leads, generate unwarranted optimism and experience more disappointment than usual. You will also be under emotional strain, and may encounter family problems. However, don't vacation and don't hide. Start on your campaign immediately!

Your great advantage will be your ability to devote your entire effort to job hunting. Invest eight or more hours each day in your job search. Strive to physically place yourself in environments populated by people who could hire you or give you referrals to others who might hire you.

If possible, get access to an office phone. It helps to have a base of operations at an office. You might be able to use the number of a friend who can have a secretary take messages for you. Even though you may be limited financially, the investment you make in your job campaign will pay you back many times over.

37 You are Attempting to Relocate

For the job seeker who is attempting to relocate, there are two major problems. One is that employers will question whether the person is serious about relocating. The other is that employers who are interested know that they will have to go to considerable extra expense for relocation costs that they would not incur if they hired someone locally.

Also, in some cases, employers may doubt the sincerity of your interest in their needs versus your personal priorities.

If you are attempting to relocate, you want to eliminate these obstacles. Start with your resume. As a first step, establish a local address and phone number through family or friends. As an alternative, you can indicate that you "will relocate at your own expense" on your resume or letter.

Remember, simply making that statement doesn't mean that you will have to do it. If you have a strong background, they may offer to cover the relocation expenses anyway, at the time you receive an offer.

It will also be helpful if you can mention in letters and conversations that you are committed to relocating and you will be there to interview during a specific time period. This eliminates the question of how serious you are and it also lets the employer know he would not have to pay for your trip just to interview you.

The most effective way to pursue relocation -- and overcome the liability of being based far away -- is to spend time in the desired area. This may be less convenient than sending resumes and letters, but it is more effective for all but a few of the most marketable persons.

Of course, POISE and COMPASS will be especially valuable for you because they make it easy to learn about growth companies and advertised openings in virtually any area of the country. Also, FIT can supply the names of leading employers in many metropolitan areas.

38 You are Attempting to Reenter the Job Market after Raising a Family

Many women with an excellent education and a variety of skills that might be put to good use find themselves in a difficult position when they attempt to reenter the job market. For many of them, there is a kind of "culture shock," because they are facing a drastic change in their daily experience.

Looked at from another perspective, though, women who have raised a family have functioned as organizers, administrators, planners, and coordinators. They have done their share of mediation, as well. Many are excellent communicators with a high energy level and a good deal of enthusiasm. They can manage diverse projects efficiently.

If you are attempting to reenter the job market, you are probably best advised to use the functional format for your resume and include experience in volunteer and social activities when possible. Show by example that you have desirable personal traits such as initiative, resourcefulness, strong drive, integrity, etc.

Take the initiative to find out more about a particular industry or occupation in which you are interested. This will help ease the "credibility gap" you would likely face regarding your lack of specific work experience.

Before you begin to interview, speak with people in your community who have had business or other work experience. You may know some socially and others through your volunteer activities. They may offer varied assistance, serving as advisors, helpers or mentors.

One reassuring note is that hundreds of thousands of women have preceded you in this job-hunting process. They make up a major portion of the work force today, and they will be understanding with regard to your situation. Nevertheless, you must realize that it is up to you to do a good job of selling your talents. Focus on what you have to offer, what you can bring to the situation and what you will give.

Remember that no one is interested in giving you anything. They only want to hear about what they can expect from you. Present yourself as a contributor. Sell yourself as a person who has demonstrated commitment, devotion, and tolerance. Also, you can communicate an ability to be persistent, tireless, organized and adaptable.

During the interview, try to focus the conversation on those areas where the company needs help. Be prepared with SODAR stories that show you used job-related skills to achieve results in managing a family and in many other activities. Above all, be yourself and do not try to pretend you are someone that you are not.

39 You are Attempting to Switch from the Nonprofit to Private-sector

Very few people in the private sector understand the structure of government and nonprofit organizations. They don't have the least idea how someone in those organizations could function effectively in a for-profit company.

If you are coming out of government or nonprofit, you will need to take the initiative in helping private-sector employers understand how your experience and skills could be put to good use in their company.

It will be a good idea for you to check the COMPASS database for the job category you are seeking. You will quickly become familiar with the way private sector employers describe the skills they need.

On your resume, you should categorize your achievements and experience according to functions which are common to the private sector. Wherever possible, draw parallels between corporate and nonprofit or government organizations. For example, fundraising is the equivalent of sales, budget constraints are the equivalent of cost control, surplus is profit, etc.

Sometimes it's possible to show that you achieved a high level of authority and responsibility which may not have been attained by someone of the same age and experience in the corporate environment.

Frequently, government operations are so large that the number of employees and dollar values are impressive. If, on top of that, you can show that you performed to demanding standards, you may be able to relieve the concerns a private-sector employer might have.

Another suggestion is to give some careful thought beforehand to your best selling points and use SODAR stories that show you have used your skills effectively in your previous employment.

Though you will encounter a different world of work in the private sector, there is much more in common with your past than you might realize.

What's in common? Well first, money is important. You still need revenue, credit lines, budgets, accounting, controls and checkpoints. Organizational manuals, policy and procedures exist in both. Team play and communications can count for a lot in any environment.

The more you recognize and point out the similarities, the more successful you will be. Also, demonstrating a consistent pattern of superior performance which is likely to continue in the future will help.

40 You Are too Young and Inexperienced

Those who consider their youth as a liability think that others may view their lack of experience as a negative, relative to their salary and position objectives. The good news is that "Youth" is the easiest of liabilities to turn into an asset.

You will do best if you find some way to demonstrate things like interest in an industry, aggressiveness, drive, enthusiasm for a field, ability to learn quickly, and natural problem-solving talents. If you are short on work history, you will probably find a functional resume most effective. By highlighting a number of functions plus skill and knowledge areas, you will focus the reader's attention away from your age and limited years of experience.

Draw upon part-time experience or extracurricular accomplishments to show your abilities. Comments on sports, volunteer work or hobbies can also be used to project a desirable personality and background. This is true whether the activities might be car racing, sky diving, coaching little league, skiing, or playing bridge.

Project yourself as mature, one who can make sound judgments in a variety of situations. With rare exception, this is not a situation where you should present yourself as an individualist who "does his own thing." Avoid extremes, emphasize career growth potential over immediate salary, and be specific in your preference for a type of job.

For graduating college students interested in opportunities within small businesses, a full-scale campaign should be prepared about two months before graduation. This time schedule may seem very close. However, small businesses normally do not have training programs or other entry-level jobs which would be open for any length of time.

41 You Have Gaps in Your Work History

You are not alone if you have gaps in your work history. This has become common as our economy goes through major restructuring. People lose jobs for a variety of reasons and it is widely known that it's not so simple to surface an equally suitable opportunity. Still, the potential employer who finds a gap in your work history will very likely question you about it. It is wise to be prepared.

On the resume, there is no need to draw attention to gaps before you've had the opportunity to present yourself in person. One way to avoid this is to use a functional or achievement format, placing your chronology on the back page.

Another approach is to cite chronology only in years. Describing one term of employment from 1979 to 1982, and the next from 1983 to 1985, can obscure a gap extending from 1982 into 1983.

If the subject comes up in the interview, you will have an opportunity to turn it to your advantage. You can explain that you put the time to good use by mounting a well-thought out job campaign that is surfacing excellent new opportunities. You might also generate some positive empathy by describing the difficulties you faced in avoiding the temptation to take an offer that wasn't right.

You can go further and stress that it is very important to find the right job this time, so that you never have another gap. As a final note, you can point out that the experience has made you more appreciative of a good job, and that you will offer a greater degree of dedication and loyalty than the average person.

42 You Have Stayed too Long in One Job

The majority of employees today run the risk of staying too long in one job as the result of inertia. Very often, talented professionals will take the easy path by staying put. Years pass, and they suddenly realize that it is time to break the pattern. Probably the most difficult aspect of dealing with this liability is simply to make the decision to move on. Once that is done, you then have to devote the time, energy and resources to surfacing your "best" opportunity.

You may ask, "How long is too long to stay in one job?" There's no pat answer to that. Twenty years with a single employer and no particular recognition is obviously serious, but for some, three years without a promotion is too long.

If you feel uncertain about moving on, take a careful inventory of what you have to offer. Are you well rewarded, fully challenged and appropriately recognized? If not, it may be time for you to get going.

When you do, you may find that some employers view your staying in one job so long as an indication of inflexibility or lack of ambition. To counter that, there are a number of points that you can make on your resume or in interviews.

Whenever you have long tenure with one employer, it serves as testimony that you have been effective for that employer. They kept you on because you delivered needed results. Sell those results.

Long tenure also helps certify that you are a compatible individual who gets along with superiors, peers, subordinates, suppliers, customers, and others. Final hiring decisions are usually based upon compatibility. In other words, being with one employer for a long time can be viewed as strong testimony to both your overall effectiveness and your compatibility.

43 You Have no Experience in Small Companies

If you gained your experience in large corporations and find yourself interviewing with employers who are primarily smaller companies, you may well encounter some resistance from those who suspect that you may not be as adaptable as they would prefer. They might further presume that you would not be able to function well without the kind of staff support that is often found in large corporations.

The fact is, you probably are performance-oriented and enjoy a fast pace. (If not, you would not be seeking to make the change to a small company.) Be sure to point that out. In addition, you could even add that, as the company enters its next stage of growth, it will be facing many problems with which you are already familiar. Sell your ability to transfer successful techniques and methods of the large company to benefit a new, smaller employer.

Your goals play an important role here also. Therefore, you should reassure the potential employer that your desire for a small-company environment is one of your primary motivations for making a move. To help your case, find out as many good things as possible about the company. Few things will impress a smaller employer more than your having personal knowledge about the history and achievements of the company.

The big danger for the large company man in these situations relates to reaction time. Smaller organizations run lean. They must reach decisions quickly and work with minimal resources. Top management frequently finds it necessary to take a short-term point of view in order to capitalize on an opportunity or even to survive. Small companies are not for the faint of heart, but they offer challenge and excitement not available in the giant corporations.

Your big advantage is that there is still a tendency for smaller, unknown employers to favor individuals with experience in the better-known firms. They respect the past accomplishments of these firms and recognize that there will be no unexpected requirements for your further training and development.

44 Your Present Employer has a Reputation for not Demanding Much of People

Justifiably or not, some corporations develop a reputation as slow paced, perhaps paying people more than they are really worth. Usually it is a large corporation, where there are some people who give 100% and others who just seem to drift along. If your employer has this problem, you may encounter resistance from those who feel that no truly ambitious person would work for such a company.

In that situation, it is important to deal head on with the negative perceptions. On the resume, you can include a statement of personal philosophy that indicates you are seeking a position in a company which demands the most of their people, provides a fast-paced environment, and gives above average rewards to above average contributors.

During the interview, discuss the issue candidly and explain what motivates you to make a change. You might indicate that you have outperformed many of your co-workers, and you now need to find an organization that will present sufficient challenge. Indicate that you are ready to make new contributions on a higher level . . . in an environment where the problems and opportunities are well matched to your ability to deliver results.

45 You Have a Record of too Many Job Changes

"Job hoppers" are people who have not shown much progression within companies and who usually experience many lateral job changes. Any employer will be wary of this kind of record.

However, there is a big difference between job hoppers and those who have achieved great progress through changing jobs. There is certainly little stigma attached to the latter. Your job changing will not be a liability if you can point to significant salary and responsibility progression. In fact, there is no better evidence of employer satisfaction than a record of salary growth and advancement.

If you're afraid of being cited for too many job changes, a functional or achievement resume will allow you to downplay the number of companies you've worked for.

Your success in dealing with your record of job change will depend primarily on your reasons for leaving various situations. Acceptable reasons include mergers or acquisitions; departure of talented superiors; a need for more challenge; changes in corporate policies; a desire to relocate; financial offers which were too good to turn down.

At interviews you could explain how you gained increased responsibility for people, dollars and capital invested in equipment and facilities. Point out how you were recruited from one position to the next by people who were aware of your superior performance in the prior role. Show how you were deliberately accumulating experiences which would best qualify you for the job you are now seeking.

If you have a more serious problem in this area, it may be time to take a hard look at what is causing your need for frequent change. Chances are, you must be cautious in selecting your next job. Try to be sure that your next opportunity is with the right people, in the right industry and that their overall outlook for the future is favorable.

46 You Had Few Activities in College

If you are a recent graduate and had few extracurricular activities, some employers may view this as a negative. On the other hand, there are many excellent reasons for restricting such activities.

On your resume, you should not make a separate section for extracurricular activities. Instead, you can combine it with other information, such as sports, travel, honors, awards, leisure pursuits, or other subjects. Where appropriate, you can emphasize the variety of courses you took and your grade point average.

If you had a heavy workload, you should mention that fact, along with information about jobs during the school year and in summer. In today's busy world, many students just don't have the time and interest to devote to extracurriculars. When that is the case, it is better to avoid companies and occupations where this is important.

During the interview, be prepared to speak about those activities in which you did engage. Explain, if appropriate, that you deliberately restricted your activities to give each one sufficient time and get something meaningful out of them. You should always also emphasize positive attitudes and characteristics which may appeal to potential employers. Use them as positives in place of activities.

Also, you can choose to mention that your first priority was to attain good grades and that your second priority was to earn money to offset educational expenses. This would leave little time for extracurricular activities.

47 You Have Experience Which is Narrow

If you have single industry or single company experience, you should consider using two resumes. One would be directed at the industry in which you have experience, while the other should be a functional resume which does not emphasize the firm(s) or industry where you have spent your working life.

Stress accomplishments by area of work. For example, a brief review of the COMPASS database would show that skills in recruiting, budgeting, planning and scheduling are needed in many businesses.

Make clear the kinds of benefits you could deliver to a prospective employer. Concentrate on major contributions which have universal appeal. These include increasing revenues, cutting costs, improving growth and enhancing productivity.

Though this liability is a lot less serious than most people realize, it should be carefully considered. As a starting point, there may be a roster of company or organization alumni who can be easily traced and followed into new opportunity areas.

If you have allowed yourself to become particularly isolated, it may be worthwhile to get in touch with former college acquaintances and past social and professional contacts in order to broaden your perspective about what is happening in the world around you. Reading a selection of trade magazines can help.

Regardless of your situation, the best way to break away from being viewed as too narrow is to define your own background and interests in the broadest possible fashion. Don't look for the easy way out, but develop a solid new direction for your career. Take the time to become better informed than your competitors about new products, trends and markets. You'll be surprised at how quickly your views can change.

48 You Were Terminated from Your Most Recent Position

If you were terminated from your most recent position, then you are unemployed, so the recommendations made for unemployment would generally apply. For most people, termination today is not due to performance, but to general factors within a company or industry. If you were involved in a personal conflict, avoid discussing the details. Do not bring up any subject which will allow a hiring authority to conclude that you lacked compatibility.

Generally accepted reasons for termination include declining industry, foreign competition, negative economic trends, management reorganization, temporary layoff, staff reduction based upon seniority, etc.

Be particularly wary of new opportunities where risk of termination is high. Avoid companies with wide swings in the business cycle or volatile sales patterns. Realize that it is just as important to keep away from risky environments in the future as it is to know how to manage this increasingly feared problem.

One way to protect yourself from another termination is to talk to employees already in the company about work conditions, management philosophy and the like. They will usually surface any dangers you would want to know about.

Needless to say, there are a few other things you should keep in mind once you accept your next position: work hard, build strong relationships and produce superior results. This will help insure against a reoccurrence of the problem in the future.

49 You Made Obvious Mistakes or Were Directly Responsible for Failure

All people make mistakes! While a random survey of 100 resumes might give just the opposite impression, any seasoned employer knows people will make mistakes during their careers. Sometimes, in the case of more senior managers, the resulting failures are significant.

If you have made a significant mistake or were directly responsible for a failure, it is important for you to remember that you made more good decisions than bad ones. Chances are you were also responsible for a number of significant successes. While you should never lie about your experience, neither is it required that you emphasize your mistakes. It is your responsibility to "sell" yourself in the most positive way possible and up to your maximum potential. It is the "buyer's" responsibility to determine if there is a better candidate available elsewhere.

Your resume should focus heavily on the positives, being careful to place any negatives in the best possible light. (If profits were down, note that there was a severe recession.) Also, do not be defensive if negatives come up during interviews. Accept responsibility for your actions and redirect the conversation to your assets and potential. Be attentive to building personal rapport and relieving any tension that might be caused by discussion of the subject.

You can also share certain beneficial input with a potential employer: (1) you learn from your mistakes . . . they don't happen twice . . . (2) you have learned a little humility which will stand you well in the future . . . (3) the strength of your character has been reinforced.

Remember, some of our strongest leaders are those who made big mistakes. The important thing is, they didn't let that stop them, and went on to continued success and achievement.

50 You Switched to Your Present Position a Short Time Ago

Probably one of the most distressing experiences for someone interested in building a career is to accept a new job and then quickly find out that it just isn't right. Sometimes, it's a matter of internal politics or conflicting personalities. Or, perhaps it can be an honest misunderstanding of what the job itself would entail.

Regardless, when it happens, it is best to face up to the situation and take corrective action as quickly as possible to find a new position. You can expect that the short time in your present job will be a concern to many potential employers.

Try to demonstrate, despite the short tenure, that you made contributions of lasting value. One way to defuse objections is to leave the present position off your resume, discussing the matter as you choose in a cover letter. During interviews, be careful not to sound defensive. Simply explain that, for a valid reason, you are seeking to cut the situation short.

The reason could be that you performed well, but could not meet your expectations, or that once in the job, you realized it was not what you had been told. The explanation should show that you deal with problems, even your own, in a forthright manner.

A word of caution! You should realize that the interviewer is going to be skeptical. Plan for this and be ready to put your best foot forward. It will help if you say that it was in your employer's best interests that you make a move quickly. You can turn this potential liability into an asset by stating that the experience has given you a determination to find a company where you can contribute over a long term.

51 You May be Considered too Much of a Generalist

Few of us start out in life with the idea that, "I will become a generalist," or "I will become a specialist." Nevertheless, people move from job to job without ever building specialist skills. When that happens, you become a generalist in the eyes of many.

The major problem the so-called generalist faces is that he will be viewed in such a broad fashion that he will have no "practical" value to his next employer.

To deal with this problem, you will want to devote extra care in developing career and industry directions that you are comfortable with. Once this is accomplished, you should hone in on specific qualifications that will enhance your credibility as it relates to your goals.

Break your experience down into functional components. Develop examples of successes you have had in several diverse functions matched to the key needs and requirements of the position you seek.

Young people should be particularly cautious about being labeled a generalist too early in their careers. Adjust your presentation during each interview so that extra attention is paid to the interviewer's needs. Steer him away from looking at you as a generalist by talking primarily about the company's problems.

Wearing the mantle of "generalist" will usually not be an asset until you have moved up in responsibility and reached the executive ranks. The general management function, by definition, calls for a generalist.

Interviewing

10/26/90
Mellon Bank
2nd Interview Form

CORPORATE BANKING DEPARTMENT
Interviewing Guide
Second Interview
Corporate Lending

Candidate Name: ______________________________

School: ______________________________ Interview Date: ______________

Rating Scale: 1 - less than acceptable
2 - acceptable
3 - more than acceptable
4 - extremely acceptable

- INTERVIEWER I -

SCHOOL-RELATED QUESTIONS	RESPONSE NOTES	RATING
1. Judgment/Decision-Making: Why did you decide to get an MBA degree (or a major in ________ for your BA/BS degree)? • What alternatives did you consider? • How did you reach your decision?		☐
2. Leadership/Working with Others: Give me an example of a time when you were involved with other students in accomplishing a challenging assignment. • What was your role? • How did you get your ideas accepted by the group? • How did you deal with group members who did not pull their weight? • What was the result?		☐

SCHOOL-RELATED QUESTIONS	RESPONSE NOTES	RATING
3. Work Standards: Tell me about a time in school when you were particularly satisfied with your performance. • What satisfied you most about your performance?		☐
4. Resilience: Describe a time at school or work when you encountered a major disappointment. • How did you stay on track during that period?		☐
5. Work Standards: Describe a time during the last year when you worked under considerable pressure. • How did you maintain an acceptable performance level?		☐

(Please rate the three other behaviours on page 5 as well; additional questions are not required)

- INTERVIEWER II -

WORK-RELATED QUESTIONS	RESPONSE NOTES	RATING
(Questions should pertain to the job that is most closely related to business or banking. If the candidate has had no work experience, most of these questions may be tailored to a school-related situation.)		
6. Problem-Solving/Analytical Skills: What was the most difficult problem you had to solve on the job? • How did you go about resolving it?		☐

WORK-RELATED QUESTIONS	RESPONSE NOTES	RATING
7. Persuasiveness: Describe a time when you were effective in presenting an idea or proposal to others. • What did you take into account when preparing your presentation? • What was the outcome?		☐
8. Tenacity: Tell me about a time when you started something that you didn't want to complete. • Did you complete it? • If you completed it, how did you stay motivated? • If you didn't complete it, what were your reasons for dropping it?		☐
9. Adaptability/Flexibility: Tell me about a time in college when something unexpected happened which got in the way of reaching a goal. • What changes did you make to reach your goal? • Was there something you could have done differently?		☐
10. Why did you leave this job?		☐

(Please rate the three other behaviours on page 5 as well; additional questions are not required)

- INTERVIEWER III -

CAREER-RELATED QUESTIONS	RESPONSE NOTES	RATING
(Please complete the response note section for questions 11-15 and the comments section on the last page)		
11. Describe the kind of work environment in which you would like to work most.		☐
12. Why are you interested in banking? • What aspect of banking appeals to you most? Why?		☐
13. What can you draw on from your background to convince me that you have the skills and knowledge necessary to become a corporate lender?		☐
14. Why should we offer you the job rather than one of your classmates (or another candidate)?		☐
15. Why are your interested in Mellon Bank?		☐

(Please rate the three other behaviours on page 5 as well; additional questions are not required)

Complete for Each.Interview: Observable Behaviour

OTHER SKILLS	OBSERVATION NOTES	RATING
The following skills can be observed during the course of the interview. Make appropriate observation notations and supply a rating that reflects your evaluation of candidate's ability to use each behaviour appropriately:		
•IMPACT/RAPPORT BUILDING: Projects professionalism, self-confidence, expertise and enthusiasm; causes interviewer to listen, creates a good first impression and commanding respect		☐
•LISTENING/QUESTIONING: Asks pertinent and probing questions; seeks clarification during the interview		☐
•ORAL COMMUNICATIONS: Articulates ideas and concepts clearly and simply; is concise and succinct in explanations; utilizes appropriate grammar and sentence structure; makes transitions smoothly from one thought to another		☐

_____ I strongly recommend we hire candidate.

_____ I recommend we hire candidate.

_____ I recommend we hire candidate with some reservations (See below).

_____ I do not recommend we hire candidate.

SIGNATURE ______________________________

RETURN TO: D. J. O'Loughlin
Room 1M4448

COMMENTS: ______________________________

STAGES AND TOPICS COVERED DURING THE INITIAL INTERVIEW

(The screened area highlights the most important parts of the interview.)

STAGES	INTERVIEWER TOPICS	INTERVIEWER LOOKS FOR
1. FIRST IMPRESSIONS	Introduction and greeting Small talk about traffic conditions, the weather, the record of the basketball team	Firm handshake, eye contact Appearance and dress appropriate to the business, not campus, setting Ease in social situations, good manners, poise
2. YOUR RECORD	**EDUCATION** Reasons for choice of school and major Grades; effort required for them Special areas of interest Courses enjoyed most and least; reasons Special achievements, toughest problems Value of education as career preparation Reaction to teachers High school record, SAT scores **WORK EXPERIENCE** Nature of jobs held Why undertaken Level of responsibility reached Duties liked most and least Supervisory experience Relations with others **ACTIVITIES AND INTERESTS** Role in extracurricular, athletic, community, and social service activities Personal interests—hobbies, cultural interests, sports	Intellectual abilities Breadth and depth of knowledge Relevance of course work to career interests Special or general interest Value placed on achievement Willingness to work hard Relation between ability and achievement Reaction to authority Ability to cope with problems Sensible use of resources (time, energy, money) High energy level, vitality, enthusiasm Leadership ability; interest in responsibility Willingness to follow directions Ability to get along with others Seriousness of purpose Ability to motivate oneself, to make things happen Positive "can do" attitude Diversity of interests Awareness of world outside the lab Social conscience; good citizenship
3. YOUR CAREER GOALS	Type of work desired Immediate objectives Long-term objectives Interest in this company Other companies being considered Desire for further education/training Geographical preferences and limitations Attitude toward relocation Health factors that might affect job performance	Realistic knowledge of strengths and weaknesses Preparation for employment Knowledge of opportunities Seriousness of purpose, career-oriented rather than job-oriented Knowledge of the company Real interest in the company Work interests in line with talents Company's chance to get and keep you
4. THE COMPANY	Company opportunities Where you might fit Current and future projects Major divisions and departments Training programs, educational and other benefits	Informed and relevant questions Indications of interest in answers Appropriate but not undue interest in salary or benefits
5. CONCLUSION	Further steps you should take (application form, transcript, references) Further steps company will take; outline how application handled, to which departments it will be sent, time of notification of decision Cordial farewell	Candidate's attention to information as a sign of continued interest

WHAT DOES THE EMPLOYER LOOK FOR IN HIS EMPLOYEES?

WHAT DOES HE LOOK FOR?	HOW DO YOU LET HIM KNOW YOU HAVE IT?
1. Self confidence in ability to do the job.	A. Describe your work experience related to the job. B. Describe training or education which prepares you for the job.
2. An ability to get along with your employees.	A. Be friendly, but not overbearing in the interview. B. Tell the employer before he asks that one thing you have learned from working is how to get along with people.
3. Knowledge of the job, or the company.	A. In the beginning of the interview briefly describe the job such as "I would like to apply for the shipping clerk position. I have held similar jobs in the past and I am interested in working here." B. Questions, if good, can indicate your enthusiasm for working with the firm. Such as "How many people would I be working with in the bookkeeping department?" "I've used your tire pump for a long time. Do you make any other pumps?" "I know many airlines offer pass privileges as a fringe benefit. What is this company's policy?" "In my last job I used a Burroughs bookkeeping machine. What brand do you use here?"
4. Dependability	A. Be on time for the interview! B. Follow through on the "call back" closing.

"IF YOU HAVE NOTHING TO LOSE IF SUCCESSFUL...AND EVERYTHING TO GAIN BY TRYING WHY NOT TRY AND KEEP ON TRYING?"

5. Ability to fit company image on and off the job.	A. Dress appropriately for the job. B. Don't degrade the company's products or comment on their polluting type properties, or what you consider "ba uses". The company probably doesn't want its employees picketing them fo a cleaner environment.
6. As few as possible personal or environmental problems.	A. Don't describe problems you have which would not affect your job performance. B. Describe how you compensate for any problems you have which will affect your job performance.

"THOSE WHO GET HIRED ARE NOT NECESSARILY THE ONES WHO CAN DO THE JOB BEST BUT THE ONES WHO KNOW THE MOST ABOUT HOW TO GET HIRED!!!!

appendix 42

APPROPRIATE RESPONSES TO TYPICAL INTERVIEW QUESTIONS

An interviewer has the task of discovering what kind of person and worker you are in the short time period of about an hour or even less. Therefore, the questions asked by interviewers are fairly standard from one interview to another since all interviewers are trying to obtain the same type of information. On the following pages, these typical questions will be listed with a description of how you should answer each one.

1. TELL ME ABOUT YOURSELF

When an interviewer says, "Tell me about yourself," he is asking you to tell him about yourself as a person, not merely about your job skills. The type of answer you should give follows the same guidelines as you followed in providing personal information in your résumé, and you can refer back to this to remind yourself about what you should include. Try especially to provide information that may indicate something you have in common with the interviewer, so that you are no longer a stranger to him. Perhaps his children attend the same school as yours do, or you follow the same sports, or have lived in the same city, or his parents had a background similar to yours, or you have the same hobby. These are the specific items you should mention:

1. *Previously Met* If you have met or seen the interviewer before or heard any favorable comments about him, tell him so.
2. *Common Friend* If you know someone who works in the company or who knows the interviewer, mention him since this establishes a common acquaintance.
3. *Hobbies and Special Interests* Tell him what your hobbies or special interests are, especially if they might be job related, such as drawing, building gadgets, designing your own clothes, doing seasonal work as a tax preparer, fixing cars. Also include non-job-related special interests such as being a strong football fan, coin collecting, and keeping tropical fish.
4. *Clubs and Organizations* Tell him about clubs or organizations you belong to such as Elks, ACLU, Bridge Club, bowling club, VFW, League of Women Voters, or PTA. This tells him what kind of person you are, and it is possible that he belongs to one of them or has in the past or has a family member who does.
5. *Personal Stability* Mention any facts about yourself that indicate personal stability and trustworthiness. Owning a home indicates your desire to stay in the area, as does your having lived in the area a long time. Marriage and children also carries this message. Tell him about your desire to stay in this area and what you like about it.
6. *Parents and Spouse* Briefly tell the interviewer about your husband (wife) and parents, describing something noteworthy about their background and occupation.

Only after you have described these personal items should you talk about your job skills and experience. Almost all interviewers will ask you to talk about the personal factors, but even if they don't, try to mention them since the topic serves to create a friendly atmosphere. Then mention the following work related factors:

1. Your interest and experiences related to the job
2. Your past work experience
3. Your training or education
4. Your strong interest and enjoyment of your work

2. HAVE YOU EVER DONE THIS KIND OF WORK BEFORE?

You should never say "no" to this type of question, since no two jobs are alike and so, of course, you have never done exactly this same work. In all jobs, new skills and rules and details must be learned. A cook in one restaurant will never be preparing exactly the same foods with exactly the same equipment and exactly the same schedule as in any other restaurant. What the interviewer wants to know is whether you can learn to do the job in a reasonable time. Consequently, mention all of the experience you have had that makes it likely that you can learn quickly to do the work required in this specific job. Tell him about:

1. Your past experience
2. Your education and training related to the job
3. Nonpaid experience related to the job
4. How quickly you have learned that type of work in the past

As an example, the school principal asks you if you have taught Spanish, since the opening is for someone who can also teach one Spanish class. You haven't, but you would tell him that you took Spanish in college, have taught grammar and English, have an aptitude for languages, had spent time in Mexico, and would have no trouble handling it. Similarly, the interviewer might ask you whether you have worked as a bookkeeper and you haven't, but you could mention facts such as you kept some books as part of your previous job as secretary, you maintain an exact book of records of your family expenses, you had a bookkeeping course in high school, you're good with figures, and you're sure you could learn the necessary details quickly. If you are asked about whether you ever worked as a furniture salesman, you would similarly describe any selling experience, your interest and knowledge of furniture, your general ability as a salesman, and your assurance that you would learn very quickly.

3. WHY DO YOU WANT TO WORK HERE?

When an interviewer asks you why you wish to work for his company, he is attempting to learn whether you will be satisfied with your job and likely to stay. To reassure him you should mention as many positive features as you can about the company, such as:

1. The good reputation that the company has and your pride in telling people you work there.
2. You heard that the company is very fair and appreciates hard working employees (mention any employees who have described it to you).
3. The company has the kind of job that you are good at and like to do.
4. Convenience of job location to your home or to transportation facilities.
5. You like this type of work and you feel you can do a good job.

4. WHY DID YOU LEAVE YOUR LAST JOB?

When the interviewer asks you why you left your last job or why you want to leave your present job, he is trying to determine whether you had difficulties that may also arise in his company. This same question is also asked on some employment application forms. It has been discussed that employees usually leave a job for many reasons and that you should mention only those reasons that are favorable to you.

The fact that you did not do well in one company does not mean that you will not do well in another, so you shouldn't be concerned about leaving unmentioned any problem you might have had there. This situation might very well have been unique and would never again occur.

Some of the common reasons for leaving a job are that the company had a cut-back or a layoff, it was a seasonal job, it was a temporary job, it was only part time, it was only a good job while you were in school, it required too much travel away from home, it was not in a part of the country where you wanted to live, or the company was not doing well and could not keep up with the standard salary level. Other contributing factors may have been that you wanted to go into a different line of work for which you were well qualified and more interested, or that your company had a reorganization and didn't require the position you had any longer.

Avoid saying that you were fired, if you were; rather, mention the other factors involved, such as the job not being sufficiently oriented to your training or abilities, or that it involved a great deal of travel.

Whatever reasons you give, point out that the job for which you are being interviewed does not have the same problem as led to your leaving your last job. If you say that you left your last job because your other job involved too much travel, or was in a different area, or was not up to your skills, then point out that this job does not require travel, is in a part of the country where you want to live, or is more in line with your training aptitudes. If you were fired because of medical reasons, explain that they have been professionally taken care of. If you were fired because of family problems, assure the employer that they have been taken care of. Whatever the reason, explain in a positive manner how the situation has been, or will be, corrected.

In describing your last job, say as many positive things as you can about it even if it had many undesirable features—all jobs do. Do not say anything negative about the company or the supervisor—only that your needs did not fit in with the job. If you criticize the company or supervisor, the interviewer will view you as someone who is likely to do the same to him if you are hired in his company. On the other hand, he will regard you as appreciative and pleasant if he hears you speaking in a positive way about a company you left and will feel that you are likely to be appreciative and pleasant regarding the job for which you are interviewed.

5. WHAT KIND OF SALARY DO YOU NEED?

When you are asked about your salary requirements in an interview, the interviewer is attempting to determine whether your expectations are too high for them. Of course, you want as much as the company is willing to pay. By naming a salary at this stage of the hiring process, you can only harm yourself. If you mention a lower salary than the interviewer has in mind, you may be hired at a level less than is standard and below what you might have obtained. If you mention a higher salary, it may be more than what he had been thinking of paying and he may well terminate the interview and decide he can't afford you. The wisest course is to avoid mentioning any specific figures or even a salary range until he has decided that you are the right person for the job and has offered it to you. Having decided that you are a good potential employee, he may well decide that he is willing to start you off at a higher salary level.

One way to answer the question of your required salary level is to tell the interviewer that you would work for whatever he feels is fair based on your qualifications and the company's standard salary level for that position. You might do this by saying, "I know you'll pay as much as I'm worth to you and I can't ask for much more than that," or "You probably have set rates and whatever that is, I'd feel that was fair," or "Your company has a reputation for fairness so I know you will pay an amount that is right for me."

After the interview is over and you have definitely been offered the job, you can then decide whether the salary is high enough. If the salary offered is too low when the job has been offered, tell the employer about the problem that you have in accepting the job. Tell him that you believe you can do better elsewhere, or that you have been paid more in similar jobs in the past, or that you have another possibility or offer that pays better, whichever one of these reasons applies to you. Tell him what all of the positive attractions are of the job he has offered and how much you wish to accept if only the salary could be increased somewhat. Explain that your decision to accept would be much easier if he could find some way to offer a higher salary. If he is unable to do so, suggest that you would feel more comfortable if you had some assurance that a raise or promotion might be possible in the near future if your work will justify it.

6. WHY SHOULD WE HIRE YOU INSTEAD OF SOMEONE ELSE?

When you are asked this direct question, the interviewer is asking you, in a sense, to make his decision for him. If you have to hesitate or can think of only one or two reasons, then he will feel that the reasons are not too obvious or are not sufficient. You should quickly list your skills and positive characteristics. Some of these might be: I'm friendly and get along well with everyone; I'm very experienced; I'm very good at that type of work; I'm conscientious; I am efficient; I'm a company man for whoever I work for and give everything I've got; I don't have to be supervised and always get my job done correctly and quickly; I like this company and would enjoy working here; I'm not a clock-watcher; I'm dependable and don't take time off; I've got many extra skills that would be useful in the job besides the ones that are needed; I work harder than other people; I am always willing to work overtime and get the job done.

7. HOW MUCH WERE YOU ABSENT FROM WORK IN YOUR LAST JOB?

An employer wants to be able to depend on his employees being present, and this question is designed to determine whether he could depend on you. If you were absent a good deal because of some reason, tell the interviewer what the reason was and why you feel that will no longer be a problem. For example, "I was out for a gall bladder operation but I'm cured and that's no longer a problem. I'm in great health and don't expect to be taking any days off." If you are elderly or are a mother of young children or have some type of visible impairment such as a missing limb, this question of dependability is more likely to be asked. The same is true of some types of jobs that have an especially high absence rate and suffer a serious disruption when employees are absent, such as production line work. In answering this question, stress what your past reliability has been and give assurance of your future reliability.

8. HOW IS YOUR HEALTH?

A question about your state of health has the same intent as the previous question—how reliable an employee will you be. This is not the time to talk about your athlete's foot or an appendectomy you had as a child, or a backache or headache. The interviewer wishes to know whether you are likely to be absent because of health problems. You almost certainly do not intend to let health problems interfere with your job and so you should tell him that "My health is excellent" or "I have no health problems that will interfere with my work." Depending on your specific history, you could say, "I've never been out of work because of illness" or "I've never been out of work for sickness for more than one day at a time" or "I don't let small things interfere with my job."

If you have a physical problem that is not visible to others, such as a blood condition, a sore arm, a rash on your back, a slight hearing difficulty, or kidney problems, do not mention them unless they are so serious that they would prevent you from being a reliable employee. This is rarely, if ever, the case since almost all such conditions can be treated medically to a degree that enables you to function adequately in almost all jobs.

Suppose, however, that you have a physical problem that is visible to the interviewer. He will want to be reassured that it will not make you unreliable or incapable of doing your job. Examples of such physical problems are that you are in a wheelchair, you have a missing arm or leg or hand, you are blind, or you have a large hearing loss and are wearing a hearing aid. The first rule here is to have obtained a letter from your doctor to give to an interviewer stating that your physical problem does not require extensive additional treatment and does not interfere with your general ability to work.

The second rule is to mention the problem before the interviewer does, since he may feel embarrassed about discussing it and yet maintain a bias because of it.

Third, point out how you function normally in spite of the handicap by engaging in some action that you can perform that relates to your problem. For example, if you wear a visible hearing aid, ask him to whisper and turn up your volume control and repeat what he said. Or, if you have an artificial limb, pick up a piece of paper or some other object and also show him how you write. If you are in a wheelchair, show him how you can maneuver easily around the office and through doors. Tell him how well you function in spite of the disability, but be sure to actually demonstrate since the actual performance is more convincing than any statement. Then ask him to think of any situations he thinks you will have problems with and demonstrate to him how you will handle it.

The fourth rule is to point out how your disability actually makes you a better than average worker. Point out to the interviewer that when nonhandicapped workers see you working so well even with the handicap, they stop finding excuses for not being able to work very hard themselves. Also tell him that handicapped workers are usually very loyal to their employer and are less likely to complain and less likely to change jobs. These advantages apply to almost any disability, but, in addition, point out advantages that exist because of your specific disability. For example, if the employer knows you are an alcoholic, you can point out that now that you have recovered, you don't drink at all so you have less problems than most people who may occasionally have too much to drink. If the employer knows you have a criminal record, tell him that, because of your record, you can't take any chances at all and wouldn't even think of taking a pencil by mistake as other people do since you have too much to lose. If you are in a wheelchair, you can point out that you are less likely than others to wander off and talk to others since more effort is required: also, it is important to your health to stay busy constantly. If you are blind, you can point out that your other senses are more developed than normal and that you have developed the habit of maintaining constant alertness.

9. WHEN ARE YOU AVAILABLE FOR WORK?

When you are asked how soon you can start work, tell him as soon as possible. Many factors may be causing your hesitation about committing yourself, but now is not the time to mention them. You may not be sure you want the job, but this is something you can go home and think about and discuss with your friends. If you decide against it, you can call him as soon as you decide. However, if you express hesitation now, you may not receive the offer. Another hesitation you might have is that you are not sure how soon you can leave your other job, make travel arrangements, or cancel other appointments. If you mention these problems now, you may not have any reason to make these arrangements. Once the job is offered, try to make the necessary arrangements, and only if you can't should you call the employer and tell him you need the extra day or week before starting. If you find your current employer desires a week or two notice, then your new employer is likely to respect you for this and gladly allow you to start later since he knows now that you will do the same for him. A third reason for hesitation might be that you are waiting to hear about another position you applied for. In this situation, also, you should tell the interviewer you desire to start as soon as possible. Once the job is offered, you can then call the other job possibilities you have interviewed for and explain that you have an offer but would rather work at their company and request a decision before you have to make a decision. In general, an employer will have an increased estimate of your value as a worker if he knows you have other job offers, and he will also be flattered by your preference for him.

10. WHAT ARE YOUR GREATEST STRENGTHS?

When asked this type of question, mention all of your positive aspects: your skill, reliability, experience, enthusiasm, efficiency, organization, pride in a job well done, ability to get along with others, and so on. If the question is, "What is your single greatest strength?", mention something about your personal reliability, but also add that you have several major strengths and add them to your description.

11. WHAT ARE YOUR WEAKNESSES?

Do not describe any possible weaknesses when asked this question. If some weaknesses exist, such as lack of experience or reliability, you surely intend to overcome them, so there is no reason to draw attention to factors that will probably not occur. Mention nothing negative. Instead, respond by telling him that you have no weakness that will prevent you from being an excellent employee. You might also state once again briefly your strongest points at this time.

12. WHAT FIVE WORDS WOULD YOU SAY DESCRIBE YOU BEST?

When asked to select words to describe yourself, select only positive aspects. As in the previous questions, do not mention anything negative, but rather, answer as if you were asked to describe your strengths. Some words that might be appropriate include: reliable, conscientious, friendly, honest, cooperative, easy to get along with, hard-working, energetic, skilled, experienced, pride in work, responsible, respected, enthusiastic, dedicated, and likeable.

13. WHAT WAS YOUR LAST EMPLOYER'S OPINION OF YOU?

The best answer to the general question about your last employer's opinion of you is to have an open letter of recommendation from your last employer, which you can then summarize and show to the interviewer.

Unless you were fired, your employer must have thought well of you or else he would not have continued to employ you. Of course, there are always some minor annoyances that everybody feels about any other person and the same is true about employers and employees. Since you wish to emphasize your positive characteristics, mention only those items that were positive and do not mention any of the negative. Even if you recognize that there were some things about you that your employer didn't like, do not exaggerate their importance by mentioning them here. Some of the aspects of your work that you feel your employer liked or, at least, did not complain about, might be your high level of skill, your trustworthiness, your reliability, your ability to get along with some people that most others couldn't get along with, your promptness, your willingness to work overtime when needed, and your good customer relations. If you cannot think of any, try to remember a chance compliment he gave you in passing and repeat it.

If you have an open letter of recommendation, it will speak for itself and you should give it to the interviewer. If not, suggest to the interviewer that he contact your employer, and express your assurance that you would receive favorable comments such as, "I know he will speak very highly of me. I worked for him for two years."

If you were fired or did get along badly with your previous supervisor, you might consider not mentioning that particular employer on your résumé if you feel that the situation would not repeat itself with other employers. However, you must be honest, so if your application form requires you to list his name, do so. You may be surprised to learn that your employer still had a very high regard for many of your abilities even though you were fired. Of course, the interviewer may not contact him; most do not. However, assume the best and mention only those qualities that you feel the employer liked.

14. WHAT ARE YOUR LONG RANGE GOALS?

This type of question is sometimes phrased as "What kind of job do you hope to have in 10 years?" or "How long are you thinking of working for this company?" or "What are your future plans?" The interviewer is trying to find out whether you are serious about staying with this company or whether you are using this job only as a temporary stopover, or will be dissatisfied after a while. So, you should try to assure him of your intention to stay with the company and to grow in your career within the company, which, of course, you probably want to do if the job proves to be satisfying to you.

If you know beforehand that this company has many opportunities for advancement and encourages it, tell him that you "hope to become valuable to the company and to be promoted" as you earned it. However, be cautious in making this type of statement, since it can easily be interpreted as already showing dissatisfaction with the job at which you will be starting. Similarly, if you mention a particular position as your objective such as "I want, eventually, to be the head of a shipping department," your statement can easily be misinterpreted as revealing future problem competition.

The items to stress are that you like the company and that you hope to become a valuable employee to the company. As to your plans for staying with the company, reassure the interviewer with information such as "I don't plan on moving away, having a baby, getting married and moving, or going back to school," "I see no reason why I won't stay with this company for a long, long time. I know I'll be very happy with this company," "I like this area and don't ever plan on leaving," or "This job is just what I enjoy doing and I don't see any reason for leaving it."

The principle facts to mention are that you like the company, you like the work you'll be doing, you like the area, and that you have no plans that would require you to leave the job.

15. WHAT KIND OF MACHINES OR EQUIPMENT HAVE YOU WORKED WITH? WHAT KIND OF EQUIPMENT CAN YOU OPERATE?

If the interviewer asks this question, then obviously, skill in operating machines is important and you should inform him completely of your experience and capability. Be very specific in mentioning equipment by giving the exact names of the machines you have operated, if you can recall them, thereby providing evidence of your familiarity, such as saying, "I've worked with the Acme Model 85 Arc Welder," or "I've used the IBM Selectric." However, also be general and mention all machines you can operate such as "I can operate Ditto machines, mimeograph machines, and complicated copying machines that collate automatically. I can use either manual or electric typewriters or the special type that has automatic spacing. I can use lettering equipment, such as the Leroy type, and can operate a switchboard." The more equipment you can operate, the more apparent it is that you are capable of learning about any other type that might be required on this job, even if you have not operated that type. If the interviewer asks specifically about your ability to operate a machine you haven't had experience with, do not say you haven't had experience but, rather, describe what types of similar machines or other machines you can operate and express your confidence that you can learn quickly.

16. CAN YOU WORK UNDER PRESSURE OR TIGHT DEADLINES?

This question indicates that your job will involve working under pressure and deadlines, so reassure the interviewer by giving examples from paid or unpaid activities that involved deadlines and pressure. You might mention: episodes from your military service when a maneuver was made without notice; how you handled the last two days of political campaigning in your volunteer work; how well you performed when a large rush order suddenly had to be filled; how you managed to prepare for three final exams in one day in school; or how you handled a crisis when your boat was caught in a storm. Mention several examples, stressing how capable you were in rising to the occasion, that you did not mind the stress, and possibly enjoyed it.

17. HOW OLD ARE YOU?

If an interviewer asks you how old you are, he is usually expressing some concern that you are either too young or too old for the job. The general rule for you to follow is to reassure him that your age will not present a problem and, furthermore, has some advantages.

If you are an older person, the interviewer may be concerned that you cannot change your ways, that you will resent being supervised by a younger person, and that you may be very close to retirement. You should reassure him about these matters. In addition, you should point out the advantages of your advanced years, which include the facts that you are now very settled in the area and not likely to move around or change jobs frequently; that you have mature judgment and good common sense; that you have many different skills and are therefore adaptable to changing job requirements; that you have an established sense of responsibility, a long history of punctuality and reliability; and, if applicable, that customers usually have more trust in older persons.

If you are very young, the interviewer is probably concerned that you are likely to leave soon, return to school, move from the area, or be unreliable and frequently absent or late. In your answer to his question about your age, you should reassure him about each of these possibilities. In addition, mention some of the advantages of being very young, such as that you are quick and eager to learn; that you do not have any bad work habits; that you are in very good health and therefore don't expect to need to take sick time; that you are especially eager to prove yourself and so you are willing to take on any new assignments; and that you are very willing to accept criticism or suggestions because you know you have much to learn.

18. ARE YOU THINKING OF GOING BACK TO SCHOOL OR TO COLLEGE?

An interviewer will usually ask this question only of a younger applicant, and he is concerned that the person will be quitting soon, just as he was when he asked a young applicant how old he was. You should reassure him by mentioning considerations such as your desire to work for a few years or that work is very important to you, or that you have no desire to continue schooling and you want to build a future for yourself, or that you will take courses only at night. If you do not have a high school diploma, you may impress the interviewer by telling him that you definitely are going to attend classes in order to obtain your diploma, but intend doing so at night.

19. ARE YOU MARRIED?

When the interviewer asks whether you are married, he is usually concerned that your marital status may present a problem in your job. In general, the fear is that a married person may be too tied down by family responsibilities to be flexible or dependable on the job, and a single person may be too unreliable. The answer you should give involves assuring the interviewer that your married or single status will not cause any interference with the job. Furthermore, your answer should include a statement of the advantages for the job of being single or married.

If you are married, you can point out that:

1. You are not going to be changing jobs because you have family responsibilities.
2. You are established in the area and your family likes it here.
3. You are able to travel and work overtime since your marital partner knows that is part of a job and accepts that fact.
4. You have made arrangements for the care of your children while you are working and will not need time off from work if they are sick. This point is especially important for women with young children.
5. Your marital partner has a permanent job and wants to remain in this area. This point is especially important for women since employers are often concerned that the woman may have to quit to be with her husband if he leaves the area even though she is happy with her job.
6. Talk about your marital partner and children, stating what kind of job your partner does and what your children's ages are and what school they attend. The interviewer may know your partner, be interested in his type of job, or have children the same age, thereby establishing a common area of interest between you.

If you are single, you can point out that:

1. You can travel in your job or work overtime without restriction since you have no family to tie you down.
2. You like the area and have friends or relatives here and intend to stay.
3. That marriage will not cause you to move. This is especially important for single women.

20. ARE THERE ANY QUESTIONS THAT YOU HAVE?

This is often the final question that an interviewer will ask and is often asked merely as a gesture of courtesy. Do not attempt to obtain complete information about the job at this point, since you may unintentionally give the impression that you are not sure you really want the job. Wait until you have definitely been offered the job before asking questions about retirement benefits, chances for advancement, public transportation facilities, salary, and so on. This information may be critical for you in making your decision, but wait until you have been offered the job to ask about them. You should respond to this final question by giving him a compliment such as, "No, I have no questions. You've done a complete job in describing this company and the job requirements," or by indicating your strong desire to work, such as by saying, "The only question I have is 'how soon can I start work?'."

IF THERE ARE NO POSITIONS OPEN

Other Job Leads

If the interviewer says that no positions are available at this time or that you are not qualified for the job he has open, ask him about job leads at other places. Write down the name and address of the company as he tells you and ask for the name and the telephone number of the person you should contact. Obtain as many of these leads as you can from him. The interviewer will have become fairly familiar with your skills and will usually be able and very willing to tell you about other job possibilities.

Part-Time Job

Tell the interviewer you would be interested in a part-time job if he has indicated no jobs are available. Part-time jobs often develop into full-time jobs in a short period.

Call Back

Before you leave, tell the interviewer you would like to call him in a few days to learn of his decision. By calling him back, you will make certain that you have not missed out on a job because of some unforeseen problem in his being able to contact you. Ask him when it would be convenient for you to call him to learn of his decision or should he desire more information. Also, if the employer has narrowed the choice down to a small number of equally qualified applicants, your call may well result in your being chosen rather than the others. If you learn during your callback that you were not chosen, you can still use that opportunity to ask for other job leads. As you leave, be sure to thank the interviewer and reassure him of your desire to hear from him soon. Make sure you smile. Have good eye contact, shake his hand, and tell him you enjoyed your interview.

2. WHY DO YOU WANT TO WORK HERE?

This company may be just one of several where you'd be happy to land a job. You may have chosen it because you heard there was an opening, because it's close to home, or simply because it's on your list of places to try. But that isn't what the interviewer wants to hear. He wants to know that you've done your homework, that you've selected his firm as a good place to work - for some specific reason you can explain to him with enthusiasm.

What reason? Ask around: Find out the company's reputation in it's field, in the community. Check you local library for information, read the trade journals.

It's not a bad idea to choose where you want to work. And you can.

3. WHAT DO YOU EXPECT TO BE DOING FIVE YEARS FROM NOW?

If the interviewer seems secure and confident, on the way up, a show of brash ambition on you part may sit well: "In five years? I'd like to be sitting right were you're sitting!"

The purpose of this query is simply to find out whether you're a good investment. Will you leave as soon as you can afford to stay home - or, at the opposite extreme, will you quit for a better job if you're not promoted fast enough?

The best answer you can give will indicate that you are serious about work, that you are realistic about how quickly you can get ahead, and that this job - far from being a stopgap or merely a means of paying the rent - fits into a well thought-out plan you've made. (Remember, you don't necessarily have to stick to the plan. The point is that you've made one. You're not just sitting around waiting for something to happen.)

4. DO YOU PLAN TO HAVE (more) CHILDREN?

You may never be asked this question directly, or any others that would intrude into your private life as a woman, such as, "How does your husband feel about your working?"..."What will you do if he's transferred?"... "How will you manage during school vacations?" But you'd best be ready to supply the information even so. It does you no good to show irritation - much less point out that such questions are technically illegal under the Equal Employment Opportunities Act - if you really want the job.

The charitable view to take about such inquiries is this: Your employer needs to know that you won't spend his time on your husband, your children or your supermarket. Watch for chances to reassure him when he asks these questions in disguised form. For example, "Is it 'Miss' or 'Mrs.'?" really means, "Are you married?" So it's less than helpful to say although it may be true, "I use 'Ms.'"

HOW DO YOU SPEND YOUR LEISURE TIME? can be another "fishing" question: the interviewer hopes you'll mention family outings with your children, if any, so that you're the one who has opened the subject of your motherhood, not he. The same may be true with "Are you free to travel?" - which is really asking what kind of coverage you have at home.

You can cut through all this by calmly stating the facts: You have made reliable well-tested arrangements so that your homelife will not encroach on your work life, either in time or in mental energy. A good line, if you can pull it off is "The same management techniques I hope to use in your department have worked for me at home. You needn't give a second thought to my family responsibilities." If that feels a bit thick on your tongue, simply acknowledge that you too want to keep your homelife out of your office and talk aout how you and your husband have thought through the potential problem. You may be surprised to find how quickly the air is cleared when you volunteer this kind of information, showing yourself to be neither defensive nor resentful.

5. WHAT WAS YOUR PREVIOUS SALARY?

Duck this as long as you possibly can. If your earnings have been high, revealing them too soon can cut off the interview before you have had a chance to show that you're worth every cent. If they've been low, as is more often the case, naming the amount will instantly categorize you, to your disadvantage. As a career counselor once said, "Miserably underpaid women will never allow their future salaries to be compared to what they've made in the past."

The job you're interviewing for probably has a preset salary, anyway; the employer has a range in mind for that position. In the government, and most large corporations, there are pay grade levels within each job category. So you may be able to get away without answering the question by asking "What range are we talking about here?"

Or you could say "Money's important and I want to discuss it with you, but there's something I'd like to clear up first..." thereupon skipping right to a specific question that will change the subject.

A woman in a career-counseling workshop, who was then making $8,000 dodged the question of her current salary by saying - truthfully - "I'm scheduled for my third interview for a job in the $12,000 range. I think I'll be offered that but unfortunately, it's in Boston. I'd rather not leave New York."

(By the way, even if you think in terms of you weekly or monthly salary, speak in annual sums.)

But suppose you do get boxed in to confessing that you're not in the big leagues, financially. How accurately must you answer the question? You can legitimately add about 20 percent to lower the value of the fringe benefits you have received, but don't risk the big lie. Better to suggest a reason why the figure is low: "That was my apprenticeship. I'm ready for bigger things now." Or "Of course, publishing is notoriously low-paying."

And keep your head up. The real question is what the new job is worth.

6. HAVE WE COVERED EVERYTHING?

This is a tough question only if you're not ready for it, in which case you might sit, desperately trying to think of something and drawing only a blank. Actually, it's an ideal opportunity to tick off the high points of you resume again. As with your opening monologue, prepare and practice a warming-up: "Let's see now, we've talked about my experience with X and Y and Z. Did I mention that I speak Spanish? That might be helpful in dealing with your plant in Puerto Rico."

This question also invites you to ask questions of your own. If the interview hasn't already covered such matters, talk about the degree of authority that accompanies the job's responsibilities, the promotion and salary-review policies and, particularly, how high a woman of your background could expect to go in the company. The interviewer will respect you for wanting to gather as much information as you can.

The dream interview would end with the employer taking you around to see the plant or office and letting you meet a few of the people you might be working with. (Just in case, leave some time open after each interview.) If you feel that the interview has gone well, you might make this suggestion yourself. "Would it be possible for me to meet Mr. So-and-so while I'm here?" If you're lucky, the interviewer will pick up the phone then and there; you'll have your next interview set up - if not, immediately, then soon afterward.

In any case, make sure before you leave that you understand what's to happen next. Are they to call you, or vice versa? If the interviewer is vague, pick up the reins: "May I call in a week or so to learn your decision?"

Follow-up with a letter, not merely to say thank-you but to reinforce what went well, correct what went wrong and add a point you forgot to make. (There's always at least one!) You might want to enclose another copy of your resume with this letter, suggesting that the interviewer pass it along to a certain colleague he mentioned.

Try to keep in touch, even if you're not offered the job. The person who's hired in your place may not work out, or a new opening may arise a few months hence.

Using these tactics, you'll find that no interview is ever a complete failure. At worst, an unsuccessful interview gives you practice for the big one, the one that will get you the job you want.

INTERVIEW QUESTIONS

What's Legal and What Don't You Have to Answer

A half dozen federal laws protect job applicants from questions that might be used to discriminate against them. Basically, the employer must prove (if challenged) that an interview question is directly related to the duties of the job for which you are applying.

Listed below are items which can be asked during the interview and items which are illegal to ask. Your job resume and employer application form also need not contain this information. You may, however, voluntarily provide any of the information below.

You may be asked and should answer the questions:

Where have you worked before?

What duties have you performed on past jobs?

What are your short and long-range career goals?

Why are you interested in this organization?

Tell me about yourself?

What education have you completed? (If a certain level is required for the job.)

How did you learn about this job?

Who are people prepared to write or give references for you?

What is your social security number?

What is your address and phone number?

What special qualifications do you have for this job?

May I answer any questions about the job or organization?

What are your greatest strengths and greatest weaknesses?

Why does this job interest you?

Why did you select this particular career?

Are you willing to travel, to relocate?

What job skills do you have? (When specific skills are needed)

Do you have a license for the field? (if required)

(Note that questions of this type focus on the job, your specific qualifications for it, and your career goals.)

You may be asked and need not answer these questions:

Are you married?

With whom do you live?

If married, are you expecting to have children soon?

What does your spouse do?

Were your parents born in this country?

How old are you? (But, may ask if you are legally old enough to work)

Have you ever filed for bankrupcy?

Where do you bank?

Have you ever been arrested? (But, you may be asked to provide information on criminal convictions)

How tall are you?

How much do you weigh? (But may be asked about height and weight if they are necessary for the performance of a job)

How many children do you have?

If you have children, what kinds of day care arrangements have you made?

What memberships do you hold in social, religious, and community groups?

What is your military service status?

If a veteran, what kind of discharge did you receive?

Are you physically handicapped?

(Note that these questions delve into your personal life and are not legitimate occupational qualifications.)

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PERSONAL APPEARANCE

Your Health

Good appearance starts from the inside. Your eating and sleeping habits will effect your appearance. Eating a well-balanced diet and getting enough sleep will result in feeling good as well as looking good. Exercise is another area that benefits your total appearance. An active person looks more alert than an inactive person, and the body assumes a more pleasing shape.

Body Odor

It is unrealistic to consider yourself well-groomed if you have a body odor. Most body odors are caused by perspiration under your arms and in the genital area. You can easily control body odors with products available today, frequent bathing, and some special tips. Bathing is the only way to control bacterial odor after it has occurred. It is possible now to purchase products which are antiperspirants and deodorant combined. For the most effective protection, the products should be applied immediately after you bathe.

Fragrances

Fragrances applied to your person are designed to enhance your grooming. It is possible to detract from your grooming with excessive use of fragrance. Omitting it entirely deprives you of a little extra that can be a very enjoyable part of your grooming. A very important point to remember about fragrances is that they are not designed to cover unpleasant body odors. Use your fragrances to enhance your clean body, never to cover an undesirable odor. One thing you should be aware of is that when you are indoors, working closely with people, strong fragrances are offensive. Stick to the very subtle, light fragrances when you are working closely with people in offices or other enclosed areas.

Hand Care

Your hands are practically always in view. Their grooming or lack of it are almost as often noticed as your face and hair. Protect your hands by using rubber gloves and hand creams. If you wish to use polish, a clear coat or an unobtrusive pastel is appropriate for business. Black, green, blue and sparkles are not appropriate for working women. Extremely long nails and chipped polish detract from your appearance.

Hair

The main business requirement is that hair be clean and neat. Unruly styles will hamper you in business. Gently waved and somewhat full hairstyles are preferred to very curly or "glued-to-the-head" styles. How willing are you to learn the techniques needed to keep the style you select? How much time are you willing to spend daily on it to keep it attractive? How appropriate is the style for your life-style? Select a hairstyle that fits your activities. If your time is limited, do not select a hairstyle that will require alot of care.

The business world is conservative. If you wish to change your hair color, do not make a drastic change. It will not go with your complexion and will usually look harsh. Coloring can be a great deal of trouble. You will need to touch-up the roots every four weeks. If time is one of your problems, you do not need to add this to your list.

Makeup

Like clothes, faces have a certain look in business. Very simply, they are healthy, clean, and well-groomed. Start with a clean face, then apply moisturizer before anything else. A foundation gives your skin uniform color and texture. Slight imperfections in your complexion will be covered giving you a smooth, even skin tone.

Women use cosmetics to emphasize their features. Cheekbones can be emphasized with color; eyes with mascara; and lips with lipstick. Most businesswomen wear mascara and lipstick. Other cosmetics, if worn at all, are very subtle. People should not notice your makeup; they should notice the expression on your face. Use of eyeshadow is often criticized by businesspeople. If you choose to wear it at all, choose brown or gray and blend it to resemble shadows. Eyeliner must be very subtle. The purpose of blush is to contour your face and give you a healthy glow. Too much blush makes you look like a clown.

Teeth

Teeth should be brushed and flossed after each meal. A regular dental check-up every six months prevents problems from arising. Breath fresheners or mints before an interview will temporarily solve bad breath.

Basics

Let's start from the inside to the outside. What you wear under your clothes effects how clothes look. If your undergarments are missing, you are not well dressed. A bra and slip are essential garments regardless of the weather. Your main concern is to select lingerie that is comfortable next to your skin and promotes a smooth line under your clothes. Bikini-style panties stretched over a less-than-firm stomach may make unsightly bulges that show up under your clothes. A slip that is too full for the dress you are wearing may look bulky under the dress.

Hosiery must be worn to your interview no matter what the weather. Neutral, flesh tones to grey, are the proper choice. Pastels, textured, and those with ornaments are totally wrong. Do not wear them to your interview.

Shoes should be a basic, closed, plain pump with a medium heel in a solid color. The color of your shoes should compliment your outfit. Shoes should be polished and unscuffed. Never wear spiked heels, barefoot sandals, or tennis shoes. Boots are not acceptable business attire.

Clothing

What you wear to the interview is crucial. How you look has a lot to do with how you are seen. Oftentimes in the very first few minutes of the interview, the decision is made, whether it is going to be a turndown or a second interview. Dressing too casually or flamboyantly can ruin your chances. Slacks are totally unacceptable. Just as big a mistake is overdressing. The safest choice for any interview is an attractive suit or tailored dress in a conservative color worn with flesh-toned stockings and medium-heeled pumps. Even the executives in wildly creative fields (TV, music, advertising, etc.) will respect you for knowing that a job candidate should look businesslike.

Remember--40 percent of the job-seekers who stay unemployed do so because their personal appearance does not meet employer expectations. In business you are not dressing to express personal taste; you are dressing in a costume which should be designed to have an impact on your interviewer. If your clothes do not convey the message that you are competent, able, ambitious, self-confident and reliable, nothing you say or do will over come the negative signals emanating from your appearance. You are more competent and poised if you make yourself attractive, and the employer will react to you accordingly.

The ideal interview outfit is the suit. The business suit has important characteristics:

1. The jackets are tapered very little at the waist.
2. The contours of the body are obscured by the jacket.
3. The skirt is neither too full nor too tight but hangs either straight or flares gently, obscuring the contours of the body. It should cover the knee or fall one to two inches below the knee.

Because a business suit must look fresh all day, fabrics that do not wrinkle easily are best. The patterns in fabrics that look most professional are: solids, tweeds, and muted plaids. The best colors for business suits are: dark blue; medium, charcoal, or steel gray; black; camel; beige; dark maroon; and dark rust.

The business suit is worn with a blouse. Blouses with low necklines and other eye-catching treatments are distracting. You want the interviewer to look at you, not your clothes.

In addition to suits, dresses are acceptable interview wear; preferably worn with a jacket. The solid colors recommended for suits are suggested for dresses as well. Florals and feminine prints are often too casual. Long sleeves are appropriate for year-round wear. (Remember all business offices are air conditioned.) Denim, corduroy, clinging and shiny fabrics usually are not worn.

The following are NEVER acceptable for an interview:

1. Mini-skirts
2. Denim (in any form)
3. Pants
4. Leather
5. Sleeveless clothes
6. Halters or bare midriffs
7. See-through blouses
8. Socks
9. Low-cut dresses or blouses

Coats usually worn for business are of two types: a raincoat and a winter coat. Raincoats with zip-out linings are practical for most of the year. Coats should be long enough to cover the longest skirt. Short jackets are not worn to an office; save them for your ski trip.

Accessories

There is one cardinal rule: Don't wear anything that jingles, wiggles, clanks, or glitters. Accessories should be silent, understated, and unobstrusive--never sexy. Dangling earrings, charm bracelets, metal bangles, chain collections, novelty pins, or garish, attention-getting items that distract listeners from what you are saying will dilute any woman's image. Only one pair of earrings is appropriate. At no time is a nose earring acceptable.

Hats and head scarves are unacceptable for the interview. As a matter of fact, hats and head scarves should never be worn in an office.

One favorite accessory of women deserves special mention--the carryall handbag. There is no denying that women need handbags, but you do not want to drag such an encumbrance to an interview. A small handbag that matches your shoes is appropriate.

Do not wear your sunglasses even if they are prescription. It is difficult to maintain eye contact if the interviewer cannot see your eyes.

MANNERISMS

Another part of appearance that employers consider is manner. Manner refers to your personal behavior. How you act in an interview gives the employer an idea of how you might act on the job. Since you have little time to make an impression, you manner will greatly affect that impression.

Your mannner during an interview should be natural but positive. Your manner will promote good appearance if you show that you are confident. You should always show employers common courtesy. However, do not overact. Honesty and sincerity are also elements of good manner.

When you deal with others, your nonverbal behavior communicates important messages. Effective attending behavior such as eye contact is a way of nonverbally communicating: "I'm listening," "I care about you and what you have to say," "I'm open to you," "I'm comfortable with you."

The Handshake

The most established form of etiquette in our society is the handshake. When you are called in for your interview, greet the employer with a firm handshake and a smile. This is no place for "the wimpy handshake." Be sure your hands are dry before you enter the interview. A little unscented talcum powder will relieve sweaty palms.

Posture

Posture and body movement have a major impact on the way we are perceived by others. We are presumed to be confident or self-conscious, relaxed or nervous, comfortable or uncomfortable according to the postures and body movements we exhibit. You don't need someone to tell you that downcast eyes, drooping shoulders, and a shuffling step are not signs of a confident, happy person. People generally interpret erect posture as meaning you are interested, ready, and cooperative--that the persons with whom you are communicating deserve your utmost attention. Well-tailored clothes fit well on a well-postured body, not on slumped shoulders or bulging stomachs. Use a long mirror, practice walking, standing and sitting to observe how you look. Try to correct the areas that need help.

Body language instantly signals your true feelings. Here is some language that shows confidence: sit up straight settled against the back of the chair; keep arms relaxed, hands resting quietly on lap; cross your legs only at ankles; keep feet on floor.

Nod your head occasionally to indicate that you are listening or that you are agreeing or disagreeing. Don't fidget. This can suggest nervousness, impatience or a need to use the bathroom. Don't barricade yourself behind crossed arms and/or hands in front of your face. Crossed arms indicate a defensive and closed attitude.

Eye Contact

Eye contact. Look at the other person, maintain a fairly steady, but relaxed eye contact. If you find this difficult, look at the tip of the nose or at the forehead, it will seem as though you are looking at the eyes. Avoiding eye contact gives the impression that you are hiding something or you are uninterested.

Facial Expression

Smile.

Energy Level

One of the greatest strengths you can convey at an interview is energy. The interviewer will sense how motivated you are at the interview and will use this as a major factor in evaluating you.

Poise/Self Confidence

If you give the appearance of being composed and self-assured, the interviewer perceives a person who projects self-confidence, competence, and preparation. All employers are looking for this type of employee.

Paperwork

The third aspect of appearance is the paperwork needed for a successful job search. Employers require you to fill out application forms. You must have paperwork that shows employers that you are neat, complete, and accurate. Paperwork includes resume, cover letters, applications, and references. Follow the guidelines set forth in the worksheets provided for each.

PLANNING YOUR INTERVIEW

PART TWO: "THE INTERVIEW"

The resume and cover letter did the trick. The company has requested an interview. Now what?

The interview, through which most people are hired, can be one of the most frightening aspects of job hunting.

"It's not always the best person who gets the job; it's the person who had the best interview."

After you get an appointment for an interview, you have some preparations to do. You need to learn as much as you can about the company and its concerns. You need to formulate answers to questions you may be asked about yourself. And you need to prepare yourself mentally and physically for a good first impression.

Job interviews can last a few minutes or a few hours. The length of the interview depends on the interviewer, the time available, the job, and the job-seeking skills and qualifications of the applicant. Most job interviews last about thirty minutes. They begin as soon as an employer sees you--or even before. Within five minutes most employers have decided whether or not you meet their expectations.

It may be necessary to fill out an application prior to the interview. In some instances you may be asked to complete a battery of tests--this may include typing, spelling, vocabulary, and math.

Preparation

Most interviews are lost well in advance of the actual meeting by the applicant's failure to do sufficient research to understand the employer's needs.

Research the company before you interview. Know what the company does, what type of work the employees do, and how large the company is, etc. Read brochures, leaflets, talk with employees, and review annual reports. If unable to get specific information about the company, you should know about the industry in general. Learn the name of the interviewer, and if possible, the correct spelling and pronounciation. Once you have researched the company, you can decide then how best to present your qualifications and skills as they apply to the job. If you do your homework about the company, you come across as a stronger candidate. It says to the interviewer that you are serious enough about this job to do the research.

Another aspect of your research is to confirm the exact location, date, and time of your interview. Be certain the location includes good directions, correct address, floor and room number. Find the best method of transportation and estimate travel time. If you need to travel by bus, call PAT to double check your bus schedule. You can make a trial run if necessary.

Be sure you have a few copies of your resume and references with you. Bring a working pen, pencil and notepad. It is a good idea to carry a small 3x5 card containing all pertinent information you will need to complete a job application. This should include social security number, previous jobs, addresses, telephone numbers, and dates.

Punctuality

Don't be late and don't be early. Nothing makes a worse impression than arriving late. If you cannot turn up on time for the interview, what on earth would you do as an employee? If there is the remotest chance that weather, traffic or hard-to-follow directions might be a problem, leave absurdly early just to be sure. If your car is hit by a meteor, go to a phone both and ask to reschedule.

Getting to the office building 30 minutes before the appointment is good; presenting yourself to the receptionist at that time is not. It pressures the interviewer--and could make it look as though you have nothing better to do than read magazines in the waiting room. Instead, go to a nearby restaurant for a last-minute cup or coffee and a ladies' room check of your hair, makeup and clothing. It is best to greet the receptionist 15 minutes before your appointment.

Introductions

Always go to your interview alone. When you go into the reception room of the company, give your name and the time of your appointment (and the name of the interviewer if you know it). The receptionist will probably ask you to be seated and wait. Don't be alarmed if there are other people waiting, too. Be friendly, reply to all questions courteously, but do not bother the receptionist or other employees with questions.

What do you do with your belongings? In cold weather, it is best to leave your outer coat, boots, or other paraphernalia in the reception room, hang them up if there is some arrangement such as hooks, hat racks, or closets available. It is definitely awkward to carry excess clothing into the interviewer's office.

When called into the interviewer's office, what should you say first? Greet the employer with a firm handshake and a smile. Be ready with an opening statement. Remember the interviewer does not know you; so the first thing you say is your name. In your most natural manner, tell the interviewer who you are--use the interviewer's name. "Good morning/Good afternoon, Ms. Winters, I am Mary Brown. I'm here to interview for the clerical position." After you give your name, the interviewer will probably ask you to be seated. Do not sit down until the employer asks you to be seated. Sit up straight. Keep your feet on the floor and your hands on your lap. Look the interviewer in the eye; however, do not stare. If you find it hard to keep eye contact, look at the interviewer's nose or eyebrows.

Speech

After your general appearance, the next thing your interviewer notices is the way you speak. If you have not learned how to use good grammar by this time it may be too late to change very much. This makes it all the more important that you try to improve your speech skills and habits during the time you have left in school.

Do not chew gum or smoke. Gum is not a substitute for cigarettes or self-confidence. Gum chewing looks appropriate only in vintage movies about wise-cracking waitresses.

Slang words and phrases that are appropriate with your friends during your leisure time may not be appropriate in business situations. Choose your words carefully, avoiding fad phrases and local dialects. A good vocabulary is noticed and appreciated. You appear less intelligent when your vocabulary is weak and you use slang.

The rate at which you speak matters. Is it too fast or too slow? (Few are too slow.) The variation of pitch is important. Monotones are boring. Some enthusiasm for what you are saying should be reflected in varying pitch.

Listening

Few of us learn to listen. We listen only enough to know how we will respond. Once a question has been asked don't rush in with your answer before the last words are out of the interviewer's mouth. Pause for a few seconds, relax, and then respond. Silence is indeed, golden, and even a three-to-four second pause will create the impression that you are relaxed and confident. These short pauses will also give you a moment to frame your responses.

Interview Questions

Interview questions can be answered in a variety of ways. How you answer them often determines your success. When you analyze them, the types of questions themselves can be informational. Often they are asked simply to give you the opportunity to speak. You don't need to stick to simple answers; you can expand your answer to include what you want to emphasize about yourself.

An interview is not the time for surprises. To be at your best you must be ready to talk about yourself and your background. To prepare for interviews you must become familiar with the typical questions. The following pages contain lists of the common interview questions. You must be able to respond quickly and positively. Note any question that is difficult for you to answer. Think about, write down, and then practice presenting positive answers to both the easy questions and the hard ones.

This first list includes some of the most common interview questions.

1. Tell me about yourself?

The interviewer is not trying to uncover your personal problems or love life. This question is asked to find out about your job skills. It also allows the interviewer to see how well you express yourself. Be prepared to give an entire series of statements about your best qualifications for the job. Be specific and include examples to support your claims. Note that the question lets you talk about your dedication to attendance, punctuality, and dependability, as well as your skills. The following are examples:

> "I can type sixty words per minute."
>
> "I have just completed training and have learned the following skills ...."
>
> "I have experience as a ...."
>
> "I had an excellent attendance record at my last position."
>
> "I work well under pressure."
>
> "I am highly motivated and dependable."

2. What do you expect to be doing five years from now?

There are several reasons for asking this question. The interviewer may want to know if you are ambitious, plan ahead, or if you set goals for yourself. There are no correct answers. However, you should have a good positive answer prepared. The following are examples:

> "I hope to become very good at my job and perhaps take some courses to become an executive secretary."
>
> "I intend to learn the stock so well that I can become a buyer for the department."

3. What are your greatest strengths?

This is where you can tell the interviewer about your skills and achievements both in school and on the job, i.e. very organized; committed to completing a project; enjoy people, etc.

4. What are your greatest weaknesses?

This question is designed to give the interviewer negative information about you. It also tests your ability to handle tough questions. Stick to job-related information. Never be negative. Rather, turn any negative issue into a positive statement. Turn your weaknesses into a strength. Show that you are willing to work and to learn new skills. The following are examples:

> Weakness: "I'm too slow."
>
> Positive: "I'm often too careful about my work. Sometimes I work late to get my job done just right."
>
> Weakness: "I don't like people telling me what to do."
>
> Positive: "I tend to ask questions about what I am told to do so I can be sure I will do it right."

Do not tell the interviewer that you have no weaknesses. If you cannot think of one, say something positive about yourself. For example:

> "Maybe it would be my curiosity about how things work. I like to learn new skills and see how things fit together."

5. What kind of office machines can you use?

Here is where you can list the office machines you can operate. These may include the typewriter, computer, stencil maker, and copy machine.

6. Can you work under pressure and deadlines?

If the employer asks this question, you can be sure it probably means this is part of your job. Your answer should assure the employer that you can work under pressure and deadlines. You should cite examples of previous jobs or related experience where you worked under such conditions. If you ever worked at any type of production job, you can mention that you often had to fill an order in a short period of time or on short notice. If you say you cannot work under pressure, you will probably not get the job.

7. Why did you leave your last job?

The employer asks this question to find out if you had any problems on your last job. If you did, you may have the same problems on a new job. Following are some tips on how to answer this question.

> Never say anything negative about yourself or your previous employer. If you did have problems, think of a way to explain them without being negative.
>
> Be very careful not to use the word fired when explaining why you left the previous job. Perhaps you were laid off or your position was cut. Use these words to explain what happened. If you were fired, you can explain using the words, "mutual consent."
>
> Other common reasons for leaving a job are listed below:
>
> "There was a general lay-off."
>
> "The job was temporary, part-time, or seasonal."
>
> "I moved to a new area."
>
> "The company went out of business."
>
> "There was no room for advancement."
>
> "I wanted a job that would make better use of my skills."

More Interview Questions

What is the position for which you are applying?

How did you learn of this position?

What specifically about this position interests you?

Why do you want to return to work?

Do you have any special training?

Would you prefer on-the-job or a formal training program?

What can you do for this company now?

How would you be getting to work each day?

Do you have a driver's license?

Would you mind moving from this area if the company chooses to relocate you?

Can you do considerable traveling?

Would you be available for part-time work?

What hours are you available for work?

Will you be available for weekend work?

Can you work the night shift?

Will you be available for overtime work?

What did you like most about your last job?

What did you like least about your last job?

Why should I hire you?

Why do you want to work for this company?

Do you get along well with people?

Can you take instruction without becoming upset?

What do you do if you have a personality clash with your supervisor?

What if a personal problem interferes with your work?

What examples can you give that emphasize your interest in this kind of work?

How would you describe your personality?

Do you like routine work?

Do you have references?

Would your last employer recommend you?

What do you expect in terms of benefits?

What experience do you have that relates to the job you want?

Controversial Questions

Some interviewers make a practice of asking a question or two that is controversial or even illegal. Such a question might have to do with politics, religion, personal, racial matters, or economics. If this kind of question is asked, give a mild, but straightforward answer.

There are many opinions on what is legal and illegal for an employer to ask. Illegal or not, they may come up in your job search. Choosing not to answer what you feel is an illegal question may result in your losing a potential job offer. Stick to a short, simple answer to the question. Often an employer intends no harm and is simply a poor or untrained interviewer. The following are examples of controversial questions.

What is your age? Religion? Creed? Marital status?

Who lives in your household?

Do you have children? If so, what are their ages?

Do you plan on having additional children?

Who will care for your children while you are at work?

The Offender Issue

In order to respond to the offender issue correctly, you must first know your exact offense. This can be determined by researching your record at the Clerk of Courts office in the County Courthouse. You need to know if your offense is a misdemeanor or a felony. You will need to understand the difference between a charge and a conviction. If you have been fined, paroled, or placed on probation, it is considered a conviction.

Once you have determined the nature of your offense, you can deal with it honestly and openly at the interview. Withholding this information from an employer can lead to termination of your employment. An employer has the right to terminate you if an undisclosed record surfaces at a later date.

Have you ever been convicted of a misdemeanor?

Have you ever been convicted of a felony?

This question will appear on your application. You are to answer truthfully. If your answer is yes, you will write the following on the application: "Will explain at interview." When the question is asked at the interview, you should admit that you have made a mistake, but that your life is now heading in a new direction. You are seeking employment and would appreciate this chance to make a new start. If you have just finished a training class, you will want to point this out to the interviewer. Again it is imperative to emphasize the positive. It is not always necessary to go into detail about the exact circumstances, but be prepared to elaborate if asked.

If the interviewer asks for the specific offense, try to explain the charge using the least harsh language. If you have difficulty stating your specific charge, you might feel more comfortable explaining as follows:

Prostitution: "I made some poor choices in my life and was charged with solicitation."

Retail theft: "I failed to pay for some merchandise that I took."

Assault: "I had an altercation with someone."

Drugs (Alcohol): "I abused myself with drugs (alcohol)".

Bad checks: "I wrote checks without having sufficient funds."

If you are a resident of TPC, you must tell the interviewer that you are living there and that someone will be calling to verify that you are at work.

One of the last interview questions an employer may ask is "Do you have any questions?" The employer asks this as a common courtesy, and as one more test. The job seeker who has no questions will probably assume that this person has no serious interest in the position.

You will do well simply by having one or two questions ready. These questions should not be aggressive. Your questions should be assertive and show concern for the position and the company. Rather than asking what the company can do for you, ask what you can do for the company.

The following list may serve as a guide to the kind of questions you might ask at the end of the interview.

What kind of training might I expect if hired for this position?

What hours will I be working if hired?

What will my responsibilities be?

* What are the chances of advancement with this position?

Is this a salaried position or an hourly position?

Closing

Seldom will you be offered the position at the end of the interview. An employer will need some time to consider you for the position. The employer may have other applicants scheduled for interviews. Usually the interview will end with the employer saying "I'll be contacting you soon to let you know my decision." This should be your cue to begin your call-back closing. This closing arranges for you to contact the employer. You might say "I have several interviews scheduled, but I am very interested in this position. Rather than risk missing your call, when may I call you?" The employer will appreciate this expression of your interest. When you call back as scheduled, you will be able to show once more that you are reliable and punctual.

Before leaving, shake the interviewer's hand and thank her/him for their time. Be sure to use her/his name.

Immediately following your interview, a thank you note should be sent. See "Planning Your Follow-Up Letter" packet for the necessary information.

Whether you get the job or not, consider the interview as an experience. The more interviews you have, the more likely it is that you will be offered a job.

Interviewing
Follow-up.

appendix 43

AFTER INTERVIEW CHECKLIST

Fill out immediately after each interview. On the first line, write one or two words that tell where you were interviewed. On the second line, put the date. For all other entries, put a check mark if you dealt with the item satisfactorily; otherwise, put an "X" there. If you cannot remember an item, mark it with an "X."

Place of Interview________							
Date of Interview ________							
1. Arrived on time							
2. Dressed properly							
3. Friendly with secretary and all others							
4. Introduced myself to interviewer and shook hands							
5. Described my qualifications							
6. Described my other interests and activities							
7. Gave a copy of résumé							
8. Gave copies of letters of recommendation							
9. Looked at interviewer while talking							
10. Kept good posture and avoided nervous mannerisms							
11. Mentioned who referred me or friends working there							
12. Mentioned sense of responsibility and dependability							
13. Mentioned interest in part-time job							
14. Obtained other job leads (if no job now)							

—continued

15. Arranged call back in four days							
16. Thanks and handshake at end							
Questions asked for which I should review answers:							
a. Last employment and why left							
b. Marital status, age, health, handicaps							
c. Future plans							
d. My skills and experience							
e. Salary I expect							
f. Other answers							

INTERVIEW FOLLOW-UP

RATIONALE

Simply having an application on file or having gone through an interview with an employer which did not result in an immediate position, does not mean this job seeker is covered for possible future positions with that organization, or that he has done all he could to obtain that particular position. If the job seeker contacts the employer a few days after having the initial interview, the employer will be more likely to remember that particular individual. This also may indicate that this job seeker has more ambition and desire to work for this organization than another individual. A contact such as this could influence the employer's decision or cause him to remember this job seeker when a position opens up in the future.

HOW TO DO THIS

Since the object of this approach is to make the employer remember a particular individual, the best approach is to make a personal contact with the employer. Since revisiting each former interviewer would be both time consuming and expensive, the best approach for the job seeker to take is to call each of these people. Whenever a job seeker makes such a re-contact, he remembers to mention his name, the fact that he was interviewed, the position he was seeking, as well as restating his enthusiasm for obtaining that position and thanking the employer for his time. An important point which should be made here is that the job seeker should always ask for the person who interviewed him by name. This will prevent him from being connected with another person in the organization who would not know him and addressing the person by name would seem more personal which may result in the employer being more likely to remember him.

One example approach would be the following: "Hello, Mr. Smith, this is Bill Green, the person you interviewed last Thursday at 10:00 for the manager position. After speaking with you, I have decided that your organization would be an ideal place for me to work, and I was wondering if you had made a decision yet". Another example in a situation where the employer said he would call the job seeker would be, "Hello, Mr. Jones, this is Mary Smith, the girl you interviewed on Monday for the secretarial position. You mentioned that you would let me know what you decided by the end of the week. Since I have been out most of the time I thought that maybe I had missed your call so I am calling you to find out your decision, because I am very interested in working with your organization."

In situations where a telephone call cannot be used, such as when an employer cannot be contacted or when an expensive long distance call would be necessary a letter can be used. These letters should be sent out as soon as possible after the interview, preferably the next day.

PLANNING YOUR FOLLOW-UP LETTERS

An effective follow-up campaign is essential for getting offers. Effective follow-up:

1. Reminds the employer that your are unique and available
2. Reemphasizes your potential contribution and benefits to the employer
3. Clarifies any misconceptions an employer might have about you
4. Provides additional reasons for the employer to offer you the position--immediately
5. Accelerates the employer's decision-making process

After you have an interview, send a brief thank you. You can keep the communications ball rolling--and keep your name before potential employers--in letters that ask for more information or letters that inquire about the status of your application.

Two other kinds of letters are important: the letter of acceptance and the letter of rejection. Both kinds of letters should be written promptly upon accepting or rejecting a job offer.

The following pages contain the information and sample letters needed to write follow-up letters. On the page following the sample letters is a work sheet on which to write a draft of your letter. Have another person read your final draft to proofread and react to it.

Remember you may need to write other follow-up letters in the future. Keep a copy of your work sheet and update it as needed. All follow-up letters should maintain the format used in the sample letters. The same paper you used for your cover letter and resume should be used for your follow-up letter.

THE THANK YOU LETTER

Always follow up your interview with a thank you letter, not only as a courtesy, but as a lasting impression.

Type or write it up when you return home and mail it out as soon as posssible (so he'll remember you). Address your letter to the specific person with whom you interviewed. Be sure you have the correct spelling of the person's name and job title.

The first paragraph should state that you wish to thank him or her for taking the time to interview you, and mention the exact time and date of the interview.

The second paragraph should re-iterate either your possible contribution to the department/company/agency or some important topic you felt you related to well with the interviewer, such as how you would fit in, or solve a problem that was discussed, etc.

The third paragraph should mention you are looking forward to hearing from them about the results of your interview. You may state where you can be reached (telephone number).

Keep the letter short and use simple direct language as well as correct spelling and grammar.

The following pages contain sample thank you letters. Be sure to use the same format as the samples. Use the worksheet on page 6 to write your thank you letter.

Thank You Letter

○ Restates interest and enthusiasm for job
○ Compliments the company
○ Applicant expresses his understanding of job requirements
○ States willingness to come in for second interview
○ Possibly a bit too long
○ Grade: A-

4545 Easy Street
Portland, ME 04105
207-555-4554

Mr. Neal Anderson
U.S. Paper
120 Main Street
Portland, ME 04100

Dear Mr. Anderson,

I'd like to thank you for taking time to meet with me about timber management position you are creating.

I enjoyed meeting with you and got a good feeling about the level of professionalism at your company. I'm excited and intrigued by the possibility of assuming this position, especially because it is a new one.

I believe I could be a successful member of the Woodlands Department. At International Paper, I set up a timber management system that saved thousands of dollars in wasted timber.

I'm sure the experience I had managing the 10,000 acre division would be extremely helpful in the management of the timber in this new position.

My experience as a research technician of the United States Forest Fertilization Project has also given me a deep understanding of forest fertilization management, which could easily be applied to this position.

I believe I have a good understanding of the requirements of the position you are creating. I look forward to the possibility of coming on board to evaluate what you've been doing and looking for ways to do better.

Finally, I look forward to the possibility of working with you and Mr. O'Sullivan. Thank you again for meeting with me. I would very much like to make U.S. Paper known for having the most productive—at the lowest cost—timber lands in the country. If I can elaborate on my qualifications or answer any questions, I would be happy to come back for a second interview.

Sincerely,

Michael D. Jercko

February 12, 1990

Integra Financial Corporation
301 Fifth Avenue Building
Pittsburgh, PA 15222

Dear :

It was a pleasure talking to you last Thursday at your office. Our meeting was very interesting and informative. It is quite important to me that you recognized my potential for employment with Integra Financial Corporation.

While I was very interested in working for your organization, since our meeting, I am even more enthusiastic about employment as a proof operator. I realize that this is an entry level position for someone with a B.S. but I am very serious about this opportunity.

Thank you for your consideration.

Sincerely,

241 Glory Boulevard
Pittsburgh, Pennsylvania 15290
February 12, 1990

Mr. David Johnson
Associate Director
United Mental Health
236 Forbes Avenue
Pittsburgh, Pennsylvania 15244

Dear Mr. Johnson:

I appreciated the opportunity to talk with you on Friday, February 9, 1990 regarding the opening in your clerical department.

The information you shared with me about United Mental Health was excellent, and I am excited about the posssibility of applying my education and experience to the position we discussed.

If I can provide you with any additional information, please let me know. I look forward to hearing from you soon.

Yours truly,

Margaret Smith Kennedy

1622 North Shore Drive
Pittsburgh, Pennsylvania 15236
February 13, 1990

Ms. Joanna Crosley
Marketing Director
The Johnson Crumpf Company
1435 Commonwealth Avenue
Pittsburgh, Pennsylvania 15201

Dear Ms. Crosley:

Thank you for the interview on Monday, February 12, 1990 for the position of receptionist in your department.

I am certain I would contribute significantly to the daily operation of your office.

I will be contacting you within the next week to learn of your decision regarding my application. Thank you again for your time and consideration.

Yours sincerely,

Katherine Peabody

LETTER OF JOB ACCEPTANCE

Immediately after accepting a job offer, the letter of acceptance should be be written promptly. Your reply to your new employer should be brief, personalized, and written in such a way as to reinforce the employer's decision to hire you. Be sure to indicate the date on which you will start work so there will be no misunderstanding. You would be surprised how many candidates do not report to work when they are expected.

Keep the following points in mind when composing your letter:

1. Accept the offer.
2. Refer to personal, written, or telephone offer.
3. Express your appreciation and pleasure at joining the company.
4. Notify new employer of your start date.
5. Address letter to the person who offered you the position.

The following two pages contain sample job acceptance letters. Use the work sheet on page 10 to write your letter of acceptance. Have another person read your final draft to proofread and react to it.

Sample Letter of Job Acceptance

111 South Elm Street
Pittsburgh, Pennsylvania 15243
February 14, 1990

Ms. Annabelle Carrington
Personnel Manager
Acme Printing, Inc.
36 Abbington Way
Pittsburgh, Pennsylvania 15211

Dear Ms. Carrington:

I am delighted to confirm my acceptance of the job as clerical assistant. As you already know, I am not going to report for another two weeks. But I have just given my present firm two weeks notice, and will report to you on February 28, 1990.

Let me repeat how pleased I am at getting this job. I was hoping that I would, as I feel that it is the perfect job for me; I know that I will fit into your company well.

Looking forward to seeing and working with you on February 28.

Cordially,

Barbara Bush

Sample Letter of Job Acceptance

Two Sunflower Lane
Pittsburgh, Pennsylvania 15236
February 14, 1990

Mrs. Samantha Stevens
Heavenly Employment Agency
46 Starlight Way
Pittsburgh, Pennsylvania 15345

Dear Mrs. Stevens:

I am very pleased to accept your offer for the position of data entry operator as outlined in your letter of February 13, 1990.

As we discussed at the interview, I am able to begin work on Tuesday, February 20, 1990. At your request, I am enclosing a copy of my Clerical Training Certificate.

I look forward to meeting the challenges of the job, and I shall make every attempt to fulfill your expectations.

Sincerely,

Gladys Rogers

Enclosure

Interview Follow-up Letter

January 24, 1992

Searle Pharmaceutical Company
Mr. Tom Hatton
P.O. Box 5700
Lincoln, Nebraska 68505

Dear Mr. Hatton:

It was a pleasure talking with you on Wednesday. I found our conversation to be most interesting. It is quite important to me that you recognize my potential for employment with Searle.

I am confident of my ability to perform successfully in the pharmaceutical sales position and I am certain that hiring me will prove mutually beneficial. Thank you so much for your time and consideration. I look forward to hearing from you.

Sincerely yours,

James Kelley

WHY NO JOB WAS OFFERED

What are the reasons why you as an applicant sometimes receive only a thundering silence from prospective employers after your interview has been completed?

A well known placement director at Northwestern University recently made an interesting survey of 405 top firms to find these reasons:

1. Personality and manner; lack of poise; poor presentation of self; lack of self-confidence; timid; hesitant approach; arrogance; conceit.
2. Lack of goals and ambition, does not show interest, uncertain and indecisive about the job in question.
3. Lack of enthusiasm and interest, no evidence of initiative.
4. Poor personal appearance and careless dress.
5. Unrealistic salary demands, more interest in salary than in opportunity, unrealistic about promotion to top jobs.
6. Poor scholastic record without reasonable explanation for low grades.
7. Inability to express yourself well, poor speech habits.
8. Lack of maturity, no leadership potential.
9. Lack of preparation for the interview - failure to get information about the company and unable to ask intelligent questions.
10. Lack of interest in company and type of job they are offering.
11. Lack of extra-curricular activities without good reason.

12. Attitude of "what can you do for me" etc.
13. Objection to travel, unwilling to relocate to branch offices, plants.
14. Immediate or prolonged military obligation.
15. No vacation jobs or other work experience, and did not help finance her/his own education.

Job Interviewing

Sources of Job Leads

Your newspaper, business magazine, or trade journal contains more than just want ads to help in your job-search. (Don't forget that a company's annual report is often the best source for these same kinds of leads.) Here are other stories to look at when developing a list of contacts for your search.

- ☐ Stories about products or services in great demand. Companies with hot products may be looking to expand their workforce. You may be able to get in on the ground floor by writing a dynamic cover letter to the company before they advertise for more workers.
- ☐ Your knowledge of technological breakthroughs, new patents, discoveries, and other developments in an industry or occupation can make a big impression in your letter, especially if you can catch onto the trend before anyone else does.
- ☐ Most business sections in both business/trade magazines and newspapers run a column listing promotions, retirements, and sometimes terminations and resignations. The out-going person may create an opening you could fill.
- ☐ Contract awards. When a company successfully bids on the right to manufacture goods or perform services for another company or the government, chances are the company awarded the contract will need more workers.
- ☐ Major events, such as a world's fair or Olympics in the city in which a company is located (or a company supplying such an event) create job openings.
- ☐ The opening of a new plant or facility can create opportunities.
- ☐ Reports of increased sales and earnings, which can be found not only in external publications, but also in the company's own annual report, may signal an expansion of the workforce.
- ☐ Is the corporate headquarters moving to your city or state? Undoubtedly the firm will need local people to fill openings.
- ☐ Mergers and acquisitions can create opportunities because many workers leave a merged company in the face of an uncertain future.
- ☐ Stock underwritings of new and developing companies may foretell opportunities because there will now be capital available to fill openings and create new positions.
- ☐ Articles on meeting speakers and award-winners can provide fodder for dynamic cover letters.

Source: Jack Erdlen, chairman of Costello, Erdlen & Company; Wellesley, Massachusetts

Checklist

Your cover letter is ready for mailing! Or is it? Compare it to this checklist to see if you've written the most dynamic letter possible.

- ☐ Is it an original letter rather than a mass-produced copy?
- ☐ Is it addressed to a named individual? (unless it is a response to a blind ad)
- ☐ If it's a response to a blind ad, is the salutation nonsexist?
- ☐ Does the letter grab the reader's attention in the first paragraph?
- ☐ Is it confident without being arrogant?
- ☐ Have you left out everything negative?
- ☐ Is the letter neat and attractive?
- ☐ Is every word spelled correctly? Is all grammar, syntax, punctuation, and capitalization correct? Is the letter free of typographical errors?
- ☐ Is it no longer than one page?
- ☐ Is the letter concise and to the point?
- ☐ Does it avoid such cliches as "I have taken the liberty of sending my resume enclosed herewith"?
- ☐ If it's in response to an ad, does the letter speak to the requirements of the position?
- ☐ Is it interesting?
- ☐ Does it project the image of a person you would like to get to know better if you were the employer? Have you read it from the employer's perspective?
- ☐ Have you told the employer what you can do for him rather than what he can do for you?
- ☐ Have you presented your Unique Selling Proposition?
- ☐ If you're a recent grad, have you avoided overreliance on an academic frame of reference?
- ☐ Have you avoided pleading for favors?
- ☐ Have you avoided getting too detailed?
- ☐ Have you spelled out what kind of job you're looking for?
- ☐ Have you avoided rewriting your resume in your cover letter?
- ☐ Have you avoided describing your personal objectives in vague terms?
- ☐ Have you avoided asking for career counseling?
- ☐ Have you avoided listing hobbies or interests unless relevant to the position?
- ☐ Have you listed accomplishments?
- ☐ Is it clear where the employer can reach you during business hours? Have you ensured that either a person or a machine will take the employer's call?
- ☐ Have you used action verbs?
- ☐ Have you requested action, and told the employer you'll call for an appointment?
- ☐ Have you signed your name boldly and confidently?

EMPLOYMENT SOURCES

1. Office of Employment Security
2. Newspaper
3. Telephone Book
4. Library
5. Chamber of Commerce
6. Local - colleges, business schools
   a. Placement department
   b. Bulletin boards
7. Civil Service
   a. State
   b. County
   c. City
   d. Federal - Federal Information Center
8. Office of Vocational Rehabilitation
9. Private, non-profit agencies
10. Employment Agencies
11. Networking

I. GENERAL SOURCES

Useful for addresses and corporate information such as sales volumes, names of products and corporate officers.

1. Corporations Review. Lists information about 105 Western Pennsylvania companies, 83 community or civic organizations and 10 universities and colleges. Job & Career Education Center (JCEC); Pennsylvania Division.

2. Book of Business Lists. Published by the Pittsburgh Business Times has brief information about a wide range of businesses and organizations in Pittsburgh. JCEC.

3. Pennsylvania State Industrial Directory. Lists industries of Pennsylvania by county. Pennsylvania Division; Sci/Tech.

4. Industrial Directory of Manufacturing Plants in Allegheny County. Issued by the Pittsburgh Chamber of Commerce. Pennsylvania Division.

5. Major Firms in the Pittsburgh Metropolitan Area. Published by the Pittsburgh Chamber of Commerce. Pennsylvania Division.

6. Pennsylvania Job Bank: a comprehensive guide to major employers. JCEC; Pennsylvania Division.

7. For those interested in information on smaller firms; The Smaller Manufacturers' Council publishes a: Classified Directory of Products and Services. Pennsylvania Division.

8. Standard and Poor's Corporation Directory. Lists alphabetically the names of major U.S. Corporations and their officers. Volume 3 is a geographical volume giving information on firms in specific cities and/or states. Reference Department.

9. Moody's Industrial Manual and the Transportation, Utility and Banking/Finance Manuals give company histories as well as addresses. Good to search before going on an interview. Reference.

10. Annual Reports. In conjunction with company histories see the collection of annual reports. Microfilm Room.

11. Dun's Employment Opportunities Directory -- The career guide. Lists major companies and career opportunities within the company. Also includes a geographic and product breakdown. JCEC.

12. The Almanac of American Employers by Jack W. Plunkett profiles and ranks by salaries, benefits, financial stability and advancement opportunities the five hundred most successful large corporations. JCEC.

13. Research Centers Directory. Lists major research centers in the U.S. Reference.

14. College Placement Annual. Has occupational listings as well as addresses for approximately 1200 businesses. JCEC; Reference.

15. Peterson's Annual Guide to Careers and Employment. For engineers, computer scientists and physical scientists. JCEC.

16. The Northern California Job Bank. The Southern California Job Bank. The Texas Job Bank. How to get a Job in Chicago. These are comprehensive area guides to major companies. Reference.

17. Career Employment Opportunities Directory. 4 vol. set. "Source of career employment offered by numerous businesses, government agencies and professional organizations nationwide."
    1. Liberal arts and social sciences
    2. Business administration
    3. Engineering and computer sciences
    4. Sciences

18. Directory of Career Training and Development Programs. Profiles of business, government, and professional organizations which offer training programs in such fields as: management, operations development, field sales, professional development and special development. JCEC.

19. State Industrial Directories. Each state has an industrial directory. Current year is in the Business Division. Science and Technology has previous years.

20. Thomas Register of American Manufacturers. Complete set in Sci/Tech.

2. SELECTED BIBLIOGRAPHY

Books dealing with resumes and cover letters.

The Damn Good Resume Catalog: 200 Damn Good Examples, Ten Speed Press. Lists 200 sample resumes arranged in 12 broad Job Categories: Management, Human Resources, Administration Coordination, Office/Administrative Support, Finance and Accounting, Technical and Computers, Education, Therapy and Social Work, Health, Marketing and Promotion, Sales and Potpourri.

The Damn Good Resume Guide, Ten Speed Press, A no-nonsense guide to resumes. It's format is extremely easy to follow, and it has many tips on creating effective resumes. It presents many sample resumes to use as guides.

Dynamic Cover Letters, Ten Speed Press. How to sell yourself to an employer by writing a letter that will get your resume read, get you an interview, and get you a job. Contains samples of good and poor cover letters as well as examples for other types of job seeking letters.

JOB SEARCH STRATEGIES

METHOD	STRATEGY	TOOLS	PROS	CONS
Want Ads	Scan newspaper ads. Mail resume with cover letter tailored to specific job qualifications.	• Newspapers • Journals • Cover Letters • Resumes	Involves minimal investment of time in identifying companies. Resume and cover letter are sent for actual position opening.	Resume and cover letter will compete with large number of others. Many people search ads.
Employment Agencies	Respond to employment agency ads in newspapers; check phone book for names of agencies to contact.	• Business attire • Resumes	Fee-paid jobs for graduates in technical fields, and for those with marketable experience.	Usually of less help to nontechnical/inexperienced graduates. Likely to charge fees.
Mass Mailing	Send copy of resume and general cover letter to as many companies as possible.	• Company address list • Cover letters • Resumes	May net one or two positive responses.	Cover letter and resume must be outstanding in order to compete. Anticipate many rejection letters.
Tailored Mailing	Develop good cover letter tailored to a specific type of job. Send letter with resume to selected companies.	• List of researched companies • Tailored cover letters • Resumes	Better approach than the shot-in-the-dark method of mass mailing.	Requires investment of time in researching companies and in drafting cover letters.
In-Person Visit	Visit many corporations. Submit resume and complete application.	• Business attire • Company addresses • Resumes	Resume and an application are on file with the company.	Requires a lot of time to make a relatively small number of contacts.
Inside Contacts	Ask contact working within company to circulate resume.	• List of company contacts • Resumes	May learn of unadvertised positions. May result in "courtesy interview."	A contact in itself is not enough to get you a job. You may exhaust all contacts and still not have an offer.

JOB DEVELOPMENT STRATEGIES

Example One: Personnel Representative Known

Student: Hello, may I speak with ______________________________.

Other: May I ask who is calling?

S: My name is ______________________________.

O: And what is this regarding?

E: I'm calling from the University of Pittsburgh. (STOP) If pressed, I would appreciate a few minutes of his/her time to answer a few questions for our labor market study.

O: One moment please.

E: Hello this is ______________________________ (employer).

S: My name is ______________________________. I'm from the University of Pittsburgh and am conducting a very brief labor market survey. I would just like to know if you are doing any hiring [at this time]. If not, ask if he/she anticipates hiring in the near future. If they are hiring, try to find out: 1) position 2) general requirements and tasks of the job 3) hours worked (full or part time) 4) are they located on a bus line 5) are health benefits available 6) pay rate 7) to whom the resume should be addressed. Thank you for your time.

- Remember, you usually only have a few minutes; get as much information as possible.
- Be sure to make notes of your contacts on the job development form.
- If you obtain a job leads, write the information on the job lead form and share it with other staff as soon as possible.

If you don't know the name of an individual in the personnel office, try calling the receptionist and ask her/him to give you the name of a person in personnel as you must send them a letter. Then call back at another time and ask for the person by name. Be sure to document this information and update our employer files.

Example Two: Specific Job Development

Generally, you will be searching for a particular position. Use the same script as before but see bracketed section. At that point you will say "for food service workers," for example.

A good way to develop your calling list in the absence of other lists is to use the Yellow Pages. For example, if you are job developing for printers, look up printing in the Yellow pages to formulate your list.

- Always make your list before you start making calls.

CALLING SCRIPT

When speaking on the telephone, be friendly and enthusiastic. Speak clearly. Have a pen and paper handy. If the manager isn't available when you call, ask if there's a best time to try again.

1 **Call the manager and introduce yourself:**
Good morning, is this Ms. Icanhireu?
Hi, my name is Christopher B. Jobless.

2 **Say something friendly:**
How are you this morning?

3 **Get down to business:**
Ms. Icanhireu, last week I sent you a letter plus a copy of my resume. I wanted to follow up and see if you received it.

4 **Prepare for the unexpected:**
Oh, I'm sorry to hear that you never received it. If I may, let me explain what it said: I've always admired the Wegotit Department Store and I'd like to learn about the career opportunities in your department...(don't stop - keep talking)

5 **Ask for the interview:**
...Could you possibly spare a few minutes one day, at your convenience, to explore those opportunities with me?

6 **Prepare for the "put off":**
Oh, I do understand. A lot of businesses have hiring freezes at this time of year. But, those freezes can't last forever...(don't stop - keep talking)

7 **Get the interview:**
...Frankly, I'd like to be the first called when your freeze is lifted. Couldn't you please spare a few minutes to talk to me and see where I might fit in, once the freeze is lifted?

8 **Wrap it up and confirm the date:**
Excellent. That's next Thursday at 4:15 sharp. Thanks so much. I appreciate your taking the time to meet with me.

DRAFT

FIVE STEPS INVOLVED IN APPLYING FOR A JOB

1. Develop a list of prospective employers you will contact from all of the communities in which you would be willing to work--this is your job search plan.

2. Find out as much as you can about the employers and the jobs that may be available before you actually go talk to the employer.

3. Contact the employer, preferably in person or by mail, and provide them your resume. (A completed application and copies of letters of recommendations may also be appropriate.

4. Follow-up with another visit, a letter or telephone call a week or two after the initial contact to let the employer know you are really motivated.

5. A third or fourth follow-up contact may also be appropriate (and necessary). Use your good judgement about timing the follow-up contacts and vary your methods (mail, in-person, telephone).

appendix 33

REQUEST FOR INTERVIEW CHECKLIST

	Telephone calls													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Give your name														
2. Ask for name of department head														
3. Give your name to department head and call him by his name														
4. Give your qualifications														
5. Tell him who referred you (if anyone)														
6. Ask for interview														
7. Repeat request for interview for possible openings														
8. Ask for other leads a) Name of person, company, address, telephone number b) permission to use his name														
9. Tell him you will check back														

JOB HUNTING - PART III
USING THE TELEPHONE TO SOLICIT INTERVIEWS

Here we would like to discuss the most efficient method of soliciting job interviews - the telephone call.

Once you have defined the type of job you are seeking, compile a list of firms and organizations that would seem to offer possibilities.

There are many resources for doing such research; some of them are right at hand while others will require a trip to the library. Both the yellow and white pages of your telephone directory can be an amazing source of leads. For example, suppose you have some photography and writing experience and are interested in some aspect of film production. Although Pittsburgh doesn't sound like a very promising market for such work, the yellow pages lists 27 independent film production companies here, not to mention all the advertising agencies and large industrial companies that produce their own advertising, technical and training films.

The library will offer further leads through industrial directories such as Standard and Poor's and Moody's, government directories, and "The Encyclopedia of Professional Associations." The latter will offer names and addresses both of the national headquarters of various professional associations to which you could write for local leads, and also in some cases, the local chapter or secretary.

Another important source of leads is through word-of-mouth. This may sound a little silly but it is important to let everyone know you are looking and what you are looking for. Tell friends, strangers, professors, casual acquaintances. One woman who was looking for a job in public relations mentioned the fact to a hitchhiker she picked up. It turned out that he knew the president of a local ad agency, got her an interview and yes, she was offered a job. A law student happened to mention to the travel agent who arranged his honeymoon that he wished he had a job to support his bride. Two days later the travel agent's boyfriend, a lawyer, called the student to say he needed an assistant. Another interview -- another job offer!

Once you have a tentative list, set aside a particular period each day for your telephoning and decide how many calls to make each day. Some employment specialists recommend that you make ten calls a day, others feel that five is sufficient. Let your own tolerance and energy level be your guide.

Briefly note on a piece of paper the points you wish to make so you don't mumble or fumble once you get a potential employer on the line. You might jot down such things as "Mr./Ms. _____, my name is Susan Smith. I have a background both in writing and photography and have created several short films and promotional slide-tape exhibits. I'm looking for work in industrial film production and am especially interested in __________ Co." It should not be a speech and you should not read it -- it's just there to help you in case you need help.

1.) Do not call the personnel office. Get the names of the director of whatever office you are interested in -- marketing, computer operations, public relations, etc. It's easiest to get it from the company's operator.

2.) When you reach the department head, don't ask if he or she has any openings. Merely introduce yourself briefly, mention your relevant skills, say you are interested in working for that department and ask if you might come in for an interview. Don't be put off by being told there are not current openings. Say you would still like to come in.

3.) If this receives another negative answer, ask if he or she can suggest another place you might contact for the same sort of job. If he or she makes a suggestion, say "May I use your name in making the contact?"

4.) Anytime you are unable to secure an interview, at least ask if you may send your resume to whomever you are talking to. It's better than nothing and if something opens up, he or she may remember your call and can contact you if a resume if on file.

5.) Dial the weather report or dial-a-prayer and practice a couple of times, or even better, enlist the help of a friend. Call him or her and go through your routine. Ask for criticism and feedback. You might form a mutual help group with one or more friends who are also job hunting.

Questions to Ask When Interviewing for Information

Before you conduct an informative interview, you should prepare a script of questions that you want to have answered. Don't cheat on this step. Think carefully about what questions will be most likely to uncover the information that will help you most. Your list need not exceed five questions - you don't want to make your subject feel bludgened.

Here are some suggestions to help you get started on your own list.

1. What academic degree is required for this work? Are there exceptions?
2. What skills are most important to this work? What are some ways of developing them?
3. What kinds of experience are essential?
4. If you were to change jobs, what are some other possibilities?
5. What future do you foresee for the job market in this career?
6. Are there spin-offs or developing areas that you consider interesting?
7. What kinds of experiences, paid employment or otherwise, would you most strongly recommend? What about internships or volunteer experience?
8. Are there magazines or journals in the field which I could begin reading now? Are there any books that you suggest?
9. Is there a local professional group that meets regularly? Do they offer student memberships? Whom should I contact?
10. Who else do you suggest I speak with?

I. INTRODUCTION

This booklet is not intended to be a detailed legal reference on the filling of Federal positions. The Office of Personnel Management is the authority on personnel management regulations and to comprehensively cover all the rules and regulations that cover staffing, one would have to refer to the Federal Personnel Manual. Office of Personnel Management Manual X-118 provides the minimum qualification requirements for positions in the Federal Service.

What this booklet is supposed to be, is a handy, easy to understand reference to assist community service employment representatives help their clients who are interested in Federal positions. The contents is set up to show the different ways people can be appointed to positions in the Federal Service. The different appointment authorities are not exclusive and applicants can pursue more than one of the ways to secure a Federal job and he or she can apply for more than one position. They should also understand that agencies may be considering filling a position at different grade levels and/or through more than one of the appointment authorities described.

It is very important that applicants submit the necessary forms for positions by the closing date specified in the job announcement in which they have an interest. Their application should be complete both in terms of all the items and in terms of their detailed experience. Limitations they place on geographic availability, willingness to travel, willingness to accept part-time positions, and types of positions they want to consider will effect the number of jobs for which they can be considered. Finally, we do not anticipate many jobs to be filled in the immediate future, but if only one job is filled, everyone should have an equal chance.

FEDERAL EXECUTIVE BOARD EEO COMMITTEE

2. HOW FEDERAL JOBS ARE FILLED

Most positions in the Federal Service are filled through competitive examinations. This means applicants will compete on a merit basis for the right to be referred, considered and selected. At one time, competitive examination meant almost exclusively written tests. While tests are still used in screening candidates for some positions, many positions are filled through an examination process in which your education and/or experience is evaluated relative to the position for which you wish consideration.

Office of Personnel Management - The Examination Process

WHO ARE ELIGIBLE? U. S. Citizens who meet the minimum qualification requirements stated in the job announcement.

HOW TO APPLY: Individuals interested in Federal employment should visit the Federal Job Information Center located in Room 119 of the Federal Office Building. At the Job Information Center, he or she will see listings of positions for which the Office of Personnel Management is accepting applications. The listing will show: The job title and series, salary grade level, filing period, job location, number of vacancies anticipated, where to get forms, and a control number. The applicant will either have to fill out a form and place it in a box to have the job announcement sent to him or her, or write to an Office of Personnel Management Area Office to secure it. The procedure appropriate will be spelled out on the listing.

After you apply for a position or, if required, after you take a written examination, application processing time will usually vary from 4 - 8 weeks, depending on the position and the office that is processing your application. NOTE: When you fill our the application forms, it is very important to fully complete all the required forms making sure you answer all questions and providing full details about your experience and/or education. Applications received that are missing required forms, or are incomplete in any way will be returned, thereby delaying the processing of your application.

After your application has been processed, you will receive a Notice of Rating or Notice of Results through the mail. This will show if you were found qualified (eligible) for the position for which you applied. If you were found eligible it means that your name has been placed on a list along with other eligible applicants who applied for the position.

Where the applicant's name is placed on the list, which is called a register, will be dependent upon the score he or she receives on the examination and veterans' preference entitlement. If there was no written examination, the score assigned will be based upon education and/or experience the candidate has for the job. If the candidate is a veteran, he or she will have five points added to their score. If he or she suffered a disability in the service but it has been rated at less than ten percent, he or she will have ten points added to his or her score. If they are a compensable veteran, a disability rating by the VA of ten percent or more, and they were rated eligible for the position, their name is placed at the top of the list with only other compensable veterans with higher scores ranked higher on the listing or register.

When agencies have position vacancies and have no internal candidates they wish to consider for a position vacancy, they will request names from the Office of Personnel Management of candidates from the register (listing of eligibles). Candidates will be certified to the agency with the position vacancy based upon their ranking. The agency may select from the top three candidates certified who have expressed interest in the position. Agencies will make inquiry of certified candidates to determine if they still wish consideration for the position. The agency's selection is limited to the top three candidates who have indicated their interest and availability. An agency cannot pass over a veteran with a higher score than a non-veteran. After selection is made, the register is returned to the Office of Personnel Management and the names of those candidates not selected are returned to the listing or register.

Individuals may receive inquiries as to availability and then not hear anything further. There may be several reasons for this to occur. Most frequently, the reason is that inquiries were sent to all of the candidates certified and there were three candidates with higher rankings who expressed interest. A second reason may be the position was filled through the use of one of the special appointment authorities described, the position may have been filled at a higher or lower grade, or the position was not filled because of new budgetary constraints. If candidates have questions, the Personnel Office of the agency should be able to give them the reason.

EXAMPLE OF JOB LISTINGS

IN JOB INFORMATION CENTER

```
PITTSBURG AREA OFFICE            FEDERAL JOB OPPORTUNITIES LISTING
   (NATIONWIDE)                     ISSUED:  JANUARY   24   1986                        PAGE    1
*********************************************************************************************************
      JOB TITLE            SERIES  GRADE     FILING PERIOD         JOB          VAC-    WHERE TO    CONTROL
                                   LEVEL   OPEN       CLOSE      LOCATION      ANCIES   GET FORMS    NUMBER
*********************************************************************************************************

ACCOUNTANT/AUDITOR         -510   GS-5/9    10/11/83-12/31/86  WORLDWIDE        MANY  AA-SEE LIST A  MC0007
                 REMARKS:  IF APPLYING FOR BOTH ACCOUNTANT AND AUDITOR. ONLY ONE APPLICATION IS
                           REQUIRED.  AT THIS TIME. OPPORTUNITIES ARE VERY GOOD IN THE STATES OF
                           CALIFORNIA. TEXAS. WASHINGTON. LOUISIANA. AND NEW YORK AT THE GS-9
                           LEVEL.

AGRI COMMODITY GRADER     -1980   GS-5/9    07/01/83-09/09/99  NATIONWIDE       MANY  XL-SEE LIST A  CT0001
                 REMARKS:  SPECIALTIES CURRENTLY OPEN ARE: DAIRY. MEAT. FR FRUIT/VEG GS-5/7/9:
                           POULTRY. PROC FRUIT/VEG GS-5/7: & TOBACCO GS-5.

AGRIC. MANAGEMENT SPEC.   -475    GS-5/7    10/01/85-09/30/86  NATIONWIDE       MANY  YW-SEE LIST A  WA9003
                 REMARKS:  MANAGEMENT OF FARM. LIVESTOCK OR RANCH OPERATIONS CREDIT PROGRAMS.

AIR FORCE RESERVE TECH    -0001   GS/WG     10/01/85-12/31/99  NATIONWIDE       MANY  XA-SEE LIST A  AT0071
                 REMARKS:  THE AIR FORCE HAS DELEGATED EXAMINING AUTHORITY FOR A VARIETY OF WAGE
                           GRADE & GENERAL SCHEDULE POSITIONS. CONTACT THE AIR FORCE RESERVE SEV.
                           MACON. GA FOR JOB INFORMATION. IF HIRED. MUST JOIN THE AIR FORCE
                           RESERVES.

AUDIOLOGIST               -665    GS-9/12   10/01/85-12/31/86  NATIONWIDE       MANY  XV-SEE LIST A  PN4001

AVIATION SAFETY INSPECTOR-1825    GS-9/12   01/01/86-03/31/86  FAA-NATIONWIDE   MANY  XB-SEE LIST A  D00133
                 REMARKS:  OPTION-MANUFACTURING

AVIATION SAFETY INSPECTOR-1825    GS-9/12   03/10/86-03/31/86  FAA-NATIONWIDE   MANY  XB-SEE LIST A  D00135
                 REMARKS:  OPTIONS-GEN.AVIATION OPS: AIR CARRIER OPS: AIR CARRIER AIRWORTHINESS:
                           GEN.AVIATION AIRWORTHINESS: AVIONIC AIRWORTHINESS.

BANK EXAMINER (TRAINEE)   -570    GS-5      10/01/85-09/30/86  NATIONWIDE        300    -SEE REMARKS WA9033
                 REMARKS:  APPLY TO:        FEDERAL DEPOSIT INSURANCE CORP.
                                            RECRUITMENT AND PLACEMENT BRANCH
                                            ROOM 800
                                            550 17TH STREET. NW
                                            WASHINGTON  DC 20429
```

SAMPLE OF APPLICATION REQUEST FORM
USED IN JOB INFORMATION CENTER

APPLICATION REQUEST FORM

If you wish to apply for a Federal Government position that is currently posted, please complete the information below and place this form in the DROP BOX. In order for us to respond to this request, you must be specific about the type of position that interests you.

Job Title: ______________________________

Grade or Pay: ______________________________

City or State: ______________________________
where you want to work

DISABLED ONLY: Describe the nature and degree of your disability: ______________________________

What type of assistance do you need: ____________________
____

VETERANS: If you are a disabled veteran, spouse or mother of a disabled veteran, widow or widower of a veteran, or recently (within 120 days) separated from active duty, filing deadlines may not apply to you. Please consult Pamphlet WEV-2, which is posted.

OPM Use Only

FILING EXTENSION: Closing Date ____________ Init ______

We will accept your completed application provided it is received in this office no later than ____________
WITH THIS FORM ATTACHED.

The label below will be used to mail an application packet to you. Please print clearly.

Name (First, middle and last)
Address (Number and street, or R D , or post office box no.)
City, state and Zip Code (ZIP Code must be included)

PPAO-104 (6/85)

Chances for employment depend on several factors, some of which are:

- -- The number of requests we receive to fill positions for which you are eligible.
- -- The conditions of employment required (temporary work, location of vacancy, travel, etc.) and whether you will accept those conditions.
- -- The number of people who appear on the list along with yourself.
- -- Your qualifications in comparison to others.

Since it is impossible to know all this information ahead of time, we cannot predict your chances of securing employment.

3. SPECIAL APPOINTMENT AUTHORITIES

a. TAPER means temporary appointment pending establishment of a register. This authority can be authorized by the Office of Personnel Management to an agency. It gives them recruitment authority to fill a permanent position when there are insufficient eligible applicants on a Register. After three years of TAPER service employees may be converted to career employment if their work performance has been satisfactory and they meet the qualification requirements for the position.

WHO ARE ELIGIBLE? U. S. Citizens who meet the minimum qualification requirements stated in the position vacancy announcement.

HOW TO APPLY:

The position vacancy announcement will provide information about the job(s), location, salary level, qualification requirements, application procedures, and the closing date of the position vacancy announcement. It is essential that applicants file the necessary forms prior to the announcement closing date. Otherwise, they may not be considered. Questions regarding the position vacancy announcement should be directed to the agency which has posted the position.

b. FEDERAL PAC JOBS

Trainee level Professional and Administrative Careers (PAC) are aimed toward college seniors, graduate students, and other applicants with appropriate training or experience. Regulatory and compliance work, administrative and management functions, claims and benefits examining, social services, or other technical work (as opposed to clerical or professional support occupations), generally have an entry grade of GS-5 or GS-7, and a journeyman level of GS-9 or above.

The procedures for filling these positions require that agencies first attempt to fill the jobs from within the Federal service. Since these positions are in the Excepted Service, when outside hiring is necessary for PAC positions, agencies are authorized to recruit, evaluate qualifications, and make selections from among people who apply directly to them. Persons interested in obtaining information about these jobs should contact the agencies where they wish to work.

We expect that employment opportunities for PAC positions will be limited, making competition for appointments extremely keen. In the past, the best opportunities have been in the following occupations:

Contract/Procurement - Department of Defense
Internal Revenue Officer - Internal Revenue Service
Inventory Management - Department of Defense
Quality Assurance - Department of Defense
Social Insurance Claims Examiner/Rep. - Social Security Administration
Supply Management - Department of Defense

Remember, you will need to contact each agency in which you are interested to find out if they have PAC vacancies for which you qualify.

Listed below are the entry level occupations currently covered by this hiring procedure:

Series	Title
011	Bond Sales Promotion
018	Safety Management
020	Community Planning
023	Outdoor Recreation Specialist
025	Park Management
028	Environmental Protection
080	Security Administration
101	Social Science
105	Social Insurance Administration
106	Unemployment Insurance
120	Food Assistance Program Specialist
130	Foreign Affairs
131	International Relations
132	Intelligence
140	Manpower Research and Analysis
142	Manpower Development
150	Geography
170	History
180	Psychology
184	Sociology
187	Social Sciences
190	General Anthropology
193	Archaeology
201	Personnel Management
205	Military Personnel Management
212	Personnel Staffing

Series	Title
221	Position Classification
222	Occupational Analyst
223	Salary and Wage Administration
230	Labor Management and Employee Relations
233	Labor Relations
235	Employee Development
244	Labor Management Relations Examining
246	Contractor Industrial Relations
249	Wage and Hour Compliance Specialist
301	General Clerical and Administrative
341	Administrative Officer
343	Management Analysis
345	Program Analysis
346	Logistics Management
393	Communications Specialist
501	General Accounting Clerical and Administrative
560	Budget Administration
570	Financial Institution Examining
673	Hospital Housekeeping Management
685	Public Health Program Specialist
950	Paralegal Specialist
962	Contact Representative
965	Land Law Examining
967	Passport and VISA Examining
987	Tax Law Specialist
990	General Claims Examining
991	Workmen's Compensation Claims Examining
993	Social Insurance Claims Examining
994	Unemployment Compensation Claims Examining
996	Veterans Claims Examining
997	Civil Service Retirement Claims Examining
1001	General Arts and Information (Fine and Applied Arts positions are excluded)
1015	Museum Curator
1035	Public Affairs
1082	Writing and Editing
1083	Technical Writing and Editing
1101	General Business and Industry
1102	Contract and Procurement
1103	Industrial Property Management
1104	Property Disposal
1130	Public Utility Specialist

Series	Title
1140	Trade Specialist
1145	Agricultural Program Specialist
1146	Agricultural Marketing
1147	Agricultural and Fisheries Market Reporter
1149	Wage and Hour Law Administration
1150	Industrial Specialist
1160	Financial Analysis
1163	Insurance Examining
1165	Loan Specialist
1169	Internal Revenue Officer
1170	Realty
1171	Appraising and Assessing
1173	Housing Management
1176	Building Management
1412	Technical Information Services
1420	Archivist
1421	Archives Specialist
1654	Printing Management
1701	General Education and Training
1715	Vocational Rehabilitation (For positions at GS-7 only)
1720	Education Research and Program Specialist
1812	Game Law Enforcement (GS-5)
1816	Immigration Inspection
1831	Securities Examining Compliance
1854	Alcohol, Tobacco and Firearms Inspection
1864	Public Health Quarantine Inspection
1889	Import Specialist
1890	Customs Inspection
1910	Quality Assurance Specialist
2001	General Supply
2003	Supply Program Management
2010	Inventory Management
2030	Distribution Facilities and Storage Management
2032	Packaging Specialist
2050	Supply Cataloging
2101	General Transportation
2110	Transportation Industry Analysis
2111	Transportation Rate and Tariff Examiner
2125	Highway Safety Management
2130	Traffic Management
2144	Cargo Scheduling
2150	Transportation Operations

4. SPECIAL APPOINTMENT AUTHORITY FOR THE HANDICAPPED

Handicapped individuals may be hired under competitive appointment authorities or the special appointment authorities described below.

WHO ARE ELIGIBLE? Handicapped individuals certified by a State Vocational Rehabilitation Counselor or a Veterans Administration Rehabilitation Counselor as being capable of performing the duties of the position and who meet the minimum qualification requirements.

SPECIAL APPOINTMENT AUTHORITIES

A. 700 hour Trial Appointment. To qualify, the individual must meet either:

(1) minimum qualifications for that position; or
(2) be certified by a State Vocational Rehabilitation Counselor or a Veterans Administration Rehabilitation Counselor as being capable of performing the duties of that position.

The appointment may lead to an excepted position.

B. A Schedule A Appointment. This is for an individual who meets or is certified capable. After two years in a Schedule A Appointment an individual may be non-competitively converted to a competitive appointment.

SPECIAL ACCOMMODATIONS

A. OPM, when appropriate, will use special examination procedures to assure abilities are properly assessed. Examples are:

(1) Readers
(2) Examinations in Braille
(3) Tape or large print
(4) Interpreters for test instructors
(5) Modifications of parts of a test for hearing impaired individuals
(6) Extra time to complete the test for motion impaired individuals

B. When hired, agencies will also make accommodations. Examples are:

(1) Interpreters for hearing impaired
(2) Readers for visually impaired
(3) Modified job duties
(4) Restructured work sites
(5) Altered work schedules

HOW TO APPLY

Some agencies will accept applications prior to the occurrence of a position vacancy, if the application is submitted on Standard Form 171, "Application for Federal Employment," and specifies a particular position and salary grade for which the applicant wants consideration. Other agencies which experience little turnover may not accept unsolicited applications. It would be advisable to contact the agency's personnel office regarding their policy.

6. TEMPORARY APPOINTMENTS

Federal Agencies may do their own recruiting to fill temporary positions or they may request assistance from the Office of Personnel Management. Temporary positions will be posted in The Federal Job Information Center and with the State Employment Service Office.

WHO ARE ELIGIBLE? U. S. Citizens who meet the minimum qualification requirements stated in the position vacancy announcement.

HOW TO APPLY:

The position vacancy announcement will provide information about the job(s), location, salary level, qualification requirements, application procedures, and the closing date of the position vacancy announcement. It is essential that applicants file the necessary forms prior to the announcement closing date. Otherwise, they may not be considered. Questions regarding the position vacancy announcement should be directed to the agency which has posted the position.

If there are no written tests, applicants will be rated and ranked based upon their education and/or experience which is related to the position for which they are applying. After the applicants have been assigned a rating (score), their names will be placed on a listing called a register according to score. Selection will then be made from the top ranked candidates.

7. Movement Between Agencies: Federal Employees Looking For Career Opportunities With Other Federal Agencies - Promotions & Transfers

WHO ARE ELIGIBLE? Federal employees who currently hold a career-conditional or career appointment in the Federal Service.

There are two ways in which Federal Employees may seek consideration for promotion and/or transfer to a position with another Federal agency different from the one in which they currently work.

1. Position Vacancy Announcements

Position Vacancy Announcements open to all status employees and not limited to employees of a particular agency. These announcements are circulated to the personnel offices of agencies and posted on the second floor bulletin board. However, this does not prohibit you from contacting the personnel office of agencies to inquire of such vacancies.

Interested Federal employees should follow the application procedures outlined in the position vacancy announcement. It is very important to the requirements of the job for which they are applying. They should be specific and relate all duties performed in a job reather than just those done most often.

2. Unsolicited Applications

Some agencies will accept applications prior to the occurrence of a position vacancy if the application is submitted on Standard Form 171, "Application for Federal Employment," and specifies a particular position and salary grade for which the applicant wants consideration (i. e., Management Analyst, GS-11). Other agencies who experience little turnover or have prohibitions in their union contracts which require consideration of bargaining unit employees first, may not accept unsolicited applications. It would be advisable to contact the agency's personnel office regarding their policy.

For most positions, there are experience requirements which require a year at the next lower grade performing work which is considered specialized experience. For lower graded clerical positions, this requirement may only be six months. This means that a person whose experience is in one specialized field may not qualify for a position at the same salary grade in another specialized field. If there are questions regarding eligibility, contact the personnel office of the agency to which the applicant wants to apply. Qualification requirements are stated in Civil Service Manual X-118 and applicant eligibility by the agency filling the position. These determinations are reviewed as part of agency and Office of Personnel Management audits and evaluation of the the facility's Personnel Management Program.

EMPLOYMENT OF PERSONS WITH PHYSICAL IMPAIRMENTS IN THE FEDERAL SERVICE

Policy

It is the policy of the Federal Government to provide equal employment opportunity for qualified persons with physical (includes visual and hearing) impairments in all positions where they are able to perform the job duties efficiently and safely.

Program

The Office of Personnel Management (OPM) conducts a vigorous program for applicants who are handicapped, working through its central office in Washington, D.C. and through each of its 10 regional offices and more than 60 area offices across the country.

Much of the progress of the program has been accomplished through the provisions of the Rehabilitation Act of 1973 (P.L. 93-112, as amended), which require Federal agencies to develop and implement affirmative action program plans for the hiring, placement, promotion, and retention of handicapped individuals. To facilitate employment, Federal agencies may use either competitive or special appointing authorities. Realistic physical standards, based on the actual tasks of a position, require that applicants possess only the minimum medical qualifications necessary for safe and efficient performance of the duties of a particular position. Reasonable accommodation may also be considered in determining an applicant's ability to perform the duties of a job.

The Agency Coordinator

In order to insure that all handicapped applicants receive full employment consideration, Federal agencies designate Coordinators for Selective Placement in each of their installations which have an employment office. The coordinators provide advice and counsel concerning employment and work with hiring officials to assure that handicapped applicants and employees receive full consideration for all employment and promotion opportunities.

Avenues to Employment

Competitive Appointments

Most Federal employees, including those who are handicapped, obtain their jobs competitively, through the following procedures:

- An applicant applies for and establishes eligibility on an OPM register, either by passing a written test (special testing is available for severely handicapped individuals) or by having their experience and education evaluated by OPM.
- When filling a vacancy, an agency requests a list of qualified people from the appropriate OPM register.
- The agency may then interview and select for the vacancy.

Special Appointing Authorities

Although the overwhelming majority of disabled employees in the Government obtain their jobs through the competitive procedures, there are many others for whom the ordinary procedures will not function fairly or accurately. To meet the needs of those who have severe physical impairments, an agency may use any of the following special appointing techniques. These are:

- The 700-hour trial appointing authority which gives individuals an opportunity to demonstrate their ability to perform the duties of a position. Applicants must either meet the minimum qualifications standards (including taking and passing a written test if required) or be certified by a State vocational rehabilitation (VR) counselor or a Veterans Administration (VA) rehabilitation counselor as being capable of performing the duties of the position. This is a temporary appointment which may lead to an excepted position.

- The Schedule A, section 213.3102 (u) excepted appointing authority for severely physically handicapped persons who have: (1) successfully completed a 700-hour trial appointment, or (2) have been certified directly to a position by a State VR or VA counselor.

Conversion to Competitive Service

After 2 years of successful performance in a continuing position, an employee serving in the excepted service under Schedule A, section 213.3102(u) may be noncompetitively converted to a competitive appointment upon the recommendation of his/her supervisor.

Special Accommodations

Testing

When appropriate, OPM uses special examination procedures for applicants who are physcially handicapped to assure that their abilities are properly assessed and that they are not discriminated against because of their impairments. Special testing arrangements are determined on an individual basis depending on the applicant's disability. For example: (1) readers, examinations in braille, tape, or large print for visually impaired competitors; (2) interpreters for test instructions, modifications of parts of tests for hearing impaired competitors; and (3) extra time to complete the test for motor impaired persons.

Accommodations on the Job

When Federal agencies hire a person with a physical impairment, every effort is made to accommodate the individual to insure that they can perform to their full potential and ability. Agencies may, for example: (1) provide interpreter service for the hearing impaired, (2) utilize readers for the visually impaired, (3) modify job duties, (4) restructure work sites, and (5) alter work schedules.

How to Apply

The Office of Personnel Management provides Federal job information through a network of Federal Job Information Centers (FJICs) throughout the United States. For answers to questions regarding employment in the Federal Government, you can visit, write, or call the nearest FJIC. They are listed in the white pages of most telephone directories under "U.S. Government." If one is not listed in your directory you can obtain the number of the FJIC in your state by dialing your information directory assistance operator. A call can save you unnecessary time and effort.

Other Information

Some agencies in the Federal Government are exempt by law from these procedures. For a listing of these agencies (e.g., U.S. Postal Service) contact the nearest FJIC.

Applicants who have physical impairments may need to complete physical and vocational rehabilitation processes which will enable them to meet basic qualifications. Individuals who need this assistance should contact their State Office of Vocational Rehabilitation. Veterans with service-connected disabilities should contact the Veterans Administration.

Pamphlets describing application procedures and information prepared specifically for veterans with service-connected disabilities may be obtained from the FJIC.

INFORMATION FOR PERMANENT JOB APPLICANTS

PERSONNEL SERVICE (05)
VA MEDICAL CENTER
UNIVERSITY DRIVE "C"
PITTSBURGH, PA 15240
(412) 692-3538/3580

The VA Medical Center (VAMC), University Drive (in the Oakland area) also recruits for jobs at the VAMC, Aspinwall. We do not recruit for positions at the VAMC, Highland Drive or the VA Regional Office, Federal Building. These are separate VA offices and they do their own recruitment.

Permanent Jobs — How They Are Filled

This Medical Center fills vacant permanent positions by various methods depending on the type of job, availability of qualified applicants, etc.

Recruitment and consideration of candidates for such vacancies is accomplished by using one or more methods of recruitment. Any method may be used and started or cancelled at any time in the process. Methods of recruitment may include consideration of:

1. Permanent VA employees for promotion, demotion or reassignment.
2. Former permanent Federal employees eligible for reinstatement.
3. Permanent Federal employees from other Federal agencies.
4. Candidates under special procedures for hiring the severely handicappe[illegible]
5. Veteran Readjustment Appointments Program (See attached).
6. Veterans with a compensable service connected disability of 30% or more.
7. Candidates in specific occupations for which the VA or this VAMC has direct hire authority, (i.e., physician; registered nurse; nurse anesthetist; podiatrist; optometrist; dentist; licensed practical nurse; canteen service jobs; certified respiratory, registered respiratory, corrective, physical, occupational, and recreation therapist; audiologist/speech pathologist; dietitian; librarian; medical records administrator; orthotist-prosthetist; pharmacist; clinical psychologist, social worker and diagnostic radiologic technicians).
8. Office of Personnel Management (OPM) competitive exam applicants (See attached "How Federal Jobs are filled Through the Office of Personnel Management").

Individuals who meet the criteria for one or more of the first 7 methods of recruitment may be able to file an application through or directly with this VAMC. Ask for additional information.

If you do not qualify for any of the first seven methods we will not be able to accept an application from you at this VAMC directly. You should review the information on the attached "How Federal Jobs Are Filled Through the Office of Personnel Management - Exam Process", and the sample "Federal J[illegible] Opportunities Summary" if you are interested in employment.

VETERANS READJUSTMENT APPOINTMENT PROGRAM

The Veterans Readjustment Appointment (VRA) Program is a hiring program that applies to certain Vietnam era and post-Vietnam era veterans. Employment and advancement opportunities are provided through a non-competitive appointment which leads to competitive status after satisfactory completion of two consecutive years of VRA permanent employment in a Federal job and completion of a training plan. This appointment authority allows most Federal departments and agencies to accept employment applications from VRA candidates directly.

While Federal agencies may accept an application from a qualified VRA applicant, this does not mean that the VRA applicant will be automatically considered for employment. It is only one of many recruitment methods used to fill Federal job vacancies.

VRA candidates must meet job qualification/education requirements of the position for which they are applying. All VRA applicants must have had active duty military service which exceeds 180 days (unless discharged for a service-connected disability) and discharge was not dishonorable. In addition, the veteran must meet at least one of three following requirements:

-- 1. A veteran who served on active duty after the Vietnam Era, i.e., after May 7, 1975 (A Post Vietnam Era veteran).

-- 2. A Vietnam Era veteran (VEV) who has a service-connected disability. (The Vietnam Era is August 5, 1964 to May 7, 1975)

-- 3. A Vietnam Era veteran (VEV) who has service for which a campaign badge was authorized. The campaign badges and expeditionary medals authorized for operations during the Vietnam Era include:

Vietnam Service Medal, 07/03/65 to 03/28/73;
Armed Forces Expeditionary Badges for:
- Congo, (Only for service between 11/23 - 27/64);
- Dominican Republic, 04/28/65 to 09/21/66;
- Korea, 10/01/66 to 06/30/74;
- Vietnam (includes Thailand)
  (Only for service between 08/05/64 to 07/03/65);
- Cambodia, 03/29/73 to 08/15/73;
- Cambodia Evacuation, 04/11 - 13/75;
- Vietnam Evacuation, 04/29 - 30/75;
- Army of Occupation of Berlin,
  (Only for service between 08/05/64 to 05/07/75).

TIME LIMITS ON ELIGIBILITY:

December 18, 1991 - Last date most VRA candidates may be hired. However, some recently discharged veterans may be hired up to December 31, 1993.

NEW--FOR VETERANS

Veterans Readjustment Appointments

Expanded Job Opportunities in the Federal Service

Public Law 102-16, effective March 23, 1991, makes it even easier for Federal agencies to hire Armed Forces veterans who served during and after the Vietnam era.

The VRA (Veterans Readjustment Appointment) authority is a special hiring program. Eligible veterans do not have to take examinations or compete with nonveteran candidates. VRA appointees are initially hired for a 2-year period. Successful completion of the 2-year VRA appointment leads to a permanent civil service appointment.

★ Who is eligible for a VRA appointment?

Veterans who served more than 180 days active duty, any part of which occurred during the Vietnam era (August 5, 1964 to May 7, 1975), and have other than a dishonorable discharge, are eligible if they have (1) a service-connected disability or (2) a campaign badge (for example, the Vietnam Service Medal).

Post-Vietnam-era veterans, who entered the service after May 7, 1975, are eligible if they served on active duty for more than 180 days and have other than a dishonorable discharge.

The 180-day service requirement does not apply to veterans discharged from active duty for service-connected disability.

★ How long are veterans eligible for VRA appointments after they leave the service?

Vietnam-era veterans qualify for a VRA appointment until 10 years after discharge or until December 31, 1993, whichever date is later.

Post-Vietnam-era veterans are eligible for 10 years after the date of their last discharge or until December 17, 1999, whichever date is later.

Eligible veterans with a service-connected disability of 30% or more can be hired without time limit.

★ Are there any other restrictions on eligibility for a VRA appointment?

No. Under the new VRA law, all veterans described above are eligible. (The law eliminated a previous requirement that VRA appointees have fewer than 16 years of education.)

★ What jobs can be filled under the VRA authority?

Federal agencies now can use the VRA authority to fill any white collar position up through GS 11, blue collar jobs up through WG 11, and equivalent jobs under other Federal pay systems.

★ How do veterans apply for VRA appointments?

Veterans should contact the agency personnel office where they want to work. Agencies recruit candidates and make VRA appointments directly without getting a list of candidates from OPM. Veterans can get a list of local agency personnel offices from the Veterans Representative at the OPM offices listed on the back of this sheet.

★ Are disabled veterans entitled to special consideration?

Agencies must give preference to disabled veterans over other veterans.

★ Is training available after appointment?

In some cases, agencies provide special training programs for VRA appointees. A program could include on-the-job assignments or classroom training.

★ Can VRA appointees work part-time?

Agencies may be able to set up part-time work schedules for individuals who want to attend school or handle family or other responsibilities.

(over)

United States
Office of
Personnel
Management

Career Entry Group
Staffing Policy Division

1900 E Street, NW
Washington, DC 20415-0001

CE-100
June 1991

HOW FEDERAL JOBS ARE FILLED THROUGH THE OFFICE OF PERSONNEL MANAGEMENT (OPM)

A high percentage of Federal service positions are filled through OPM Competitive Exams. For many it is the only application process available to them. Applicants are required to compete on a merit basis for the right to be referred, considered and selected. While written tests are still used in screening candidates for some positions, many positions are filled through an exam process in which your education and/or experience is evaluated relative to the position for which you wish consideration. You must meet the minimum qualification requirements stated in the OPM job announcement to be eligible.

After your application and/or written exam has been processed by OPM you will receive a Notice of Rating or Notice or Results through the mail. This notice will show if you were found qualified (eligible) for the position for which you applied. If eligible it means that your name has been placed on a list, called a register, along with other eligible applicants who applied for the position. Where your name is placed on the OPM register is dependent on the score you receive on the exam and veterans preference entitlement. If there was no written exam, your score will be based on education and/or experience. Qualified candidates that meet the requirements for Veterans Preference points may have extra points added to their score. Most will receive 5 points extra while others may receive 10 points extra (e.g., disabled veterans).

When agencies such as this VAMC have a vacancy and wish to seek candidates for consideration from the OPM register, they request from OPM a list of candidates on the register. Candidates are certified to the agency based upon their ranking. If an agency is interested in the candidates that have been certified to them, they may make an inquiry as to their availability. If an agency decides to hire a candidate from the OPM list they receive, the selection is limited to the top three candidates who have indicated their interest and availability. An agency generally cannot pass over a veteran with a higher score than a non-veteran. After a selection is made, the register is returned to OPM and the names of the candidates not selected are returned to the register.

Individuals may receive inquiries as to availability and then not hear anything further. There may be several reasons for this. Frequently, the reason is that inquiries were sent to all of the candidates certified and there were three candidates with a higher ranking who expressed interest. Other reasons include filling the position by the use of another method, filling it at a higher or lower grade, or not filling the position.

This VAMC uses the OPM Exam process to fill some positions. Most common positions include clerk, clerk-typist, medical clerk, clerk-stenographer, secretary (stenography or typing), nursing assistant, part-time food service workers and a number of medical technician and technologist positions in the lab, nuclear medicine, etc. See the attached sample "Federal Job Opportunities Summary."

ADMINISTRATIVE CAREERS WITH AMERICA

Occupational Groups

Group 1: Health, Safety and Environmental Occupations

Series	Title
0018	Safety and Occupational Health Management
0023	Outdoor Recreation Planning
0028	Environmental Protection Specialist
0673	Hospital Housekeeping Management
0685	Public Health Program Specialist

Group 2: Writing and Public Information Occupations

Series	Title
1001	General Arts and Information
1035	Public Affairs
1082	Writing and Editing
1083	Technical Writing and Editing
1147	Agricultural Market Reporting
1412	Technical Information Services
1421	Archives Specialist

Group 3: Business, Finance and Management Occupations

Series	Title
0011	Bond Sales Promotion
0106	Unemployment Insurance
0120	Food Assistance Program Specialist
0346	Logistics Management
0393	Communications Specialist
0501	Financial Administration and Programs
0560	Budget Analysis
0570	Financial Institutions Examining
1101	General Business and Industry
1102	Contract Specialist
1103	Industrial Property Management
1104	Property Disposal
1130	Public Utilities Specialist
1140	Trade Specialist
1145	Agricultural Program Specialist
1146	Agricultural Marketing
1149	Wage and Hour Law Administration
1150	Industrial Specialist
1160	Financial Analysis
1163	Insurance Examining
1165	Loan Specialist
1170	Realty
1171	Appraising and Assessing
1173	Housing Management
1174	Building Management
1910	Quality Assurance Specialist
2001	General Supply
2003	Supply Program Management
2010	Inventory Management

Group 3: Business, Finance and Management Occupations (continued)

Series	Title
2030	Distribution Facilities and Storage Management
2032	Packaging
2050	Supply Cataloging
2101	Transportation Specialist
2110	Transportation Industry Analysis
2125	Highway Safety Management
2130	Traffic Management
2150	Transportation Operations

Group 4: Personnel Administration and Computer Occupations

Series	Title
0142	Manpower Development
0201	Personnel Management
0205	Military Personnel Management
0212	Personnel Staffing
0221	Position Classification
0222	Occupational Analysis
0223	Salary and Wage Administration
0230	Employee Relations
0233	Labor Relations
0244	Labor Management Relations Examining
0246	Contractor Industrial Relations
0301	Miscellaneous Administration and Programs
0334	Computer Specialist (Trainee)
0341	Administrative Officer
0343	Management Analysis
0345	Program Analysis
1715	Vocational Rehabilitation

Group 5 Benefits Review, Tax and Legal Operations

Series	Title
0105	Social Insurance Administration
0187	Social Services
0526	Tax Technician
0950	Paralegal Specialist
0962	Contact Representative
0965	Land Law Examining
0967	Passport and Visa Examining
0987	Tax Law Specialist
0990	General Claims Examining
0991	Worker's Compensation Claims Examining

Group 5: Benefits Review, Tax and Legal Occupations (continued)

Series	Title
0993	Social Insurance Claims Examining
0994	Unemployment Compensation Claims Examining
0996	Veterans Claims Examining
0997	Civil Service Retirement Claims Examining

Group 6: Law Enforcement and Investigative Occupations

Series	Title
0025	Park Ranger
0080	Security Administration
0132	Intelligence
0249	Wage and Hour Compliance
1169	Internal Revenue Officer
1801	Civil Aviation Security Specialist
1810	General Investigator
1811	Criminal Investigator
1812	Game Law Enforcement
1816	Immigration Inspection
1831	Securities Compliance Examining
1854	Alcohol, Tobacco and Firearms Inspections
1864	Public Health Quarantine Inspections
1889	Import Specialist
1890	Customs Inspector

Group 7: Positions with Positive Education Requirements

Series	Title
0020	Community Planning
0101	Social Science
0110	Economist
0130	Foreign Affairs
0131	International Relations
0140	Manpower Research and Analysis
0150	Geography
0170	History
0180	Psychology
0184	Sociology
0190	General Anthropology
0193	Archeology
1015	Museum Curator
1420	Archivist
1701	General Education and Training
1720	Education Program

FEDERAL JOB OPPORTUNITIES
SUMMARY

FJOL NO. PH-91-06
EFFECTIVE DATE: JUNE 3, 1991

OFFICE OF PERSONNEL MANAGEMENT
PHILADELPHIA AREA OFFICE
600 ARCH STREET
PHILADELPHIA, PA 19106

SAMPLE

GENERAL INFORMATION FOR APPLICANTS

Federal Job Opportunities List (FJOL): This list provides information on positions for which applications are currently being accepted. Most positions in this list are for Pennsylvania, Camden County, NJ and Delaware.

This list is published on the 1st of each month. A supplement is issued the 16th of each month. We also publish a Nationwide List which contains federal job opportunities located anywhere in the nation or the world, not necessarily in the local area. Both lists are posted in the Federal Job Information Center (FJIC) and various State Employment Service Offices.

How to Apply: Application forms, qualification requirements and filing information can be obtained from the address in "REMARKS" or on List A (See "Forms Code" column). List A appears at the end of this listing.

Applications will be accepted only for a specific position, grade level, and work location that is currently listed on the FJOL. Applications submitted for positions, grade levels, and work locations not currently listed and incomplete application packages will not be accepted.

Be sure to pay special attention to the filing period listed for each position. Application forms will not be available, nor accepted before the opening date. Applications postmarked after the closing date will not be accepted. All Application Request Forms or written requests must be received in the office no later than the closing date for that position in order for us to respond.

Qualification Requirements: Generally, there is a separate Qualifications Information Statement (QIS) or announcement for each position. It describes the experience, education, knowledges, skills and abilities required. Be sure to read these requirements carefully. Though the QIS covers several grade levels, you may apply and be considered only for the position and grade for which applications are currently being accepted.

Citizenship and Age Requirements: United States citizenship is required for positions in the competitive service.

The minimum age for most jobs is 18 (or 16 if you are a high school graduate). Certain positions, by law, have maximum age limitations.

Notice of Results: You will be sent a Notice of Results showing whether you are eligible or ineligible. If you are eligible for a position for which a list of eligibles (competitor inventory) is maintained, your numerical rating may also be shown. For specialized positions (i.e., GS-9 and above) for which no competitor inventories are maintained, Notices do not show numerical ratings.

Starting salaries- General Schedule (GS) Positions

GS-1	$11,015	GS-5	$16,973	GS-9	$25,717	GS-13	$44,348
GS-2	$12,385	GS-6	$18,919	GS-10	$28,322	GS-14	$52,406
GS-3	$13,515	GS-7	$21,023	GS-11	$31,116	GS-15	$61,643
GS-4	$15,171	GS-8	$23,284	GS-12	$37,294		

Pay for Wage Grade (WG) Positions: The hourly wage for trades and crafts (WG) positions depends on the geographic location of the position. The current pay rate for individual Wage Grade positions is shown in the "Remarks" column of the FJOL.

Special Salary Rates: For certain positions for which there is a shortage of qualified applicants, the starting salary is higher than the normal starting salary for the grade. The FJOL indicates, where appropriate, the jobs to which special rates apply.

Temporary Positions: Federal agencies have the authority to fill certain temporary positions through special procedures. Therefore, if you are interested in temporary employment, you may apply directly to Federal agencies for consideration. Vacancy notices for these positions are posted separately in FJIC's and are available at State Employment Service Offices.

Positions Filled Under Delegated Examining Authority: Some Federal agencies have been given authority to recruit and examine directly for jobs in certain occupations. These jobs may not appear on the FJOL. Separate announcements are issued by the agency, and are posted in FJIC's and State Employment Service Centers.

Special Filing Privileges: If you are a disabled veteran, Purple Heart recipient, recently (120 days or less) discharged veteran, mother of a veteran who died in action or is totally disabled, unremarried widow/widower of a veteran, spouse of a totally disabled veteran with service connected disability, or recently (120 days or less) returned from overseas Federal civilian employment, filing deadlines may not apply to you. Contact the FJIC for additional information.

Federal Job Information Center: The Federal Job Information Center (FJIC) is open Monday through Friday from 8:30 a.m. to 3:30 p.m. You may also request forms by calling the Center at (215) 597-7440, or by writing to the Center. In the FJIC complete listings of current Federal opportunities are posted and interested applicants may obtain desired information and forms by completing an Applicant Request Form, and depositing it in the drop box in the Center. Completed application forms may also be deposited in the drop box.

THE FEDERAL GOVERNMENT IS AN EQUAL OPPORTUNITY EMPLOYER.

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PHILADELPHIA AREA OFFICE         - FEDERAL JOBS OPPORTUNITIES LISTING
     FGPA 0011                     PERIOD BEGINNING: 06/03/91                            PAGE   1
*****************************************************************************************************
         JOB TITLE                          GRADE    FILING PERIOD      JOB         VACAN-   FORMS  CONTROL
                                            LEVEL    OPEN     CLOSE    LOCATION     CIES     CODE   NUMBER
*****************************************************************************************************

ACCOUNTANT/AUDITOR                          GS-05/09  10/11/83- INDEF   NATIONWIDE      MANY     AAO*   PH0765
                           REMARKS:  ALL AGENCIES HAVE BEEN GRANTED DIRECT HIRE AUTHORITY FOR ACCT/AUD.,
                                     GS-5/7/9, FOR APPLICANTS WHO HAVE NUMERICAL RATINGS OF 80 OR ABOVE.
                                     APPLICANTS MAY FILE DIRECTLY WITH AGENCIES BY SUBMITTING SF-171 AND
                                     CURRENT NOTICE OF RESULTS. OPPORTUNITIES ARE EXCELLENT WITH DCAA IN
                                     LOS ANGELES AND SOUTH SAN FRANCISCO BAY AREAS.

ADMINISTRATIVE CAREERS WITH AMERICA         GS-05/07  04/16/91-06/30/91 SEE REMARKS     FEW      AAO*   PM6206
                           REMARKS:  SEE SEPARATE ENTRIES FOR: WRITING & PUBLIC INFO. AND HEALTH, SAFETY &
                                     ENVIRONMENTAL OCCUPATIONAL GROUPS.  EACH GROUP HAS ITS OWN TEST, APPLY
                                     SEPARATELY.  POSITIONS COVERED BY THIS ANNOUNCEMENT ARE IN ME, NH, VT,
                                     MA, CT, RI, NY, PA, NJ, DE, AND MD.  APPLICANTS WITH A GPA OF 3.5 OR
                                     HIGHER ON A 4.0 SCALE SHOULD ASK ABOUT ALTERNATIVE PROCEDURES.

AIR TRAFFIC CONTROLLER                      GS-07     04/01/86- INDEF   FAA NATIONWIDE  MANY     AAO*   PH0766
                           REMARKS:  TOWER, EN ROUTE CENTER, FLIGHT SERVICE STATION OPTIONS. MAX AGE LIMIT
                                     FOR TOWER AND CENTER IS 30. APPLY TO LOCAL OPM OFFICES FOR TESTS.

AIR-CONDITIONING EQUIPMENT MECHANIC         WG-08/10  10/01/90- INDEF   PHILA., PA      FEW (SEE REMARKS) PH2290
                           REMARKS:  FORMS MAY BE OBTAINED AT PHILA. NAVAL SHIPYARD MAIN GATE, BLDG. 501,
                                     MONDAY THRU FRIDAY, 8:00 AM TO 3:00 PM, OR BY CALLING 215-897-4480.
                                     FILE FORMS SF-171 & SUPPLEMENTAL QUESTIONNAIRE. WHEN FILING REFER TO
                                     DEA-60. $10.86, WG-8; $11.61, WG-10  FILE APPLICATION DIRECTLY WITH
                                     THE YARD, CODE 170.47, BLDG 11-2, PHILA., PA 19112.

EFITS, TAX & LEGAL OCCUPATIONS              GS-05/07  11/23/90- INDEF   NATIONWIDE      MANY     AAO*   PH2152
                           REMARKS:  THIS IS PART OF THE AMINISTRATIVE CAREERS WITH AMERICA EXAMINATIONS.
                                     A WRITTEN TEST IS REQUIRED. FILE OPM FORM 5000AB FOR ANNOUNCEMENT
                                     #0001-C. FOR FURTHER INFORMATION OR TO OBTAIN APPLICATION FORMS
                                     CONTACT ANY OPM JOB INFORMATION OFFICE OR CALL THE COLLEGE HOTLINE AT
                                     1-900-990-9200. THIS IS A TOLL CALL CHARGED TO YOU AT $.40 A MINUTE.

BIOLOGICAL SCIENCE POSITIONS                GS-05/07  10/10/85- INDEF   WORLDWIDE       MANY     AAO*   PH2167
                           REMARKS:  THERE ARE FOUR OPTIONS FOR THIS OCCUPATION: GENERAL BIOLOGIST, MICRO-
                                     BIOLOGIST, FISHERY BIOLOGIST, AND WILDLIFE BIOLOGIST.  OPPORTUNITIES
                                     ARE VERY GOOD FOR MICROBIOLOGISTS.

BOILER PLANT OPERATOR                       WG-08     08/10/90- INDEF   PHILA., PA      10 (SEE REMARKS) PH2291
                           REMARKS:  FORMS MAY BE OBTAINED AT PHILA. NAVAL SHIPYARD MAIN GATE, BLDG. 501,
                                     MONDAY THRU FRIDAY, 8:00 AM TO 3:00 PM, OR BY CALLING 215-897-4480.
                                     FILE FORMS SF-171 & SUPPLEMENTAL QUESTIONNAIRE. WHEN FILING REFER TO
                                     DEA-21A1. $10.86 PER HOUR. FILE APPLICATION DIRECTLY WITH THE YARD,
                                     CODE 170.47, BLDG 11-2, PHILA., PA 19112. ROTATING SHIFT WORK REQ.

BOILERMAKER                                 WG-08/10  01/14/90- INDEF   PHILA., PA      FEW (SEE REMARKS) PH2292
                           REMARKS:  FORMS MAY BE OBTAINED AT PHILA. NAVAL SHIPYARD MAIN GATE, BLDG. 501,
                                     MONDAY THRU FRIDAY, 3:00 AM TO 3:00 PM, OR BY CALLING 215-897-4480.
                                     FILE FORMS SF-171 & SUPPLEMENTAL QUESTIONNAIRE. WHEN FILING REFER TO
                                     DEA-15. WG-8, $10.86; WG-10, $11.61 PER HOUR. FILE APPLICATION
                                     DIRECTLY WITH THE YARD, CODE 170.47, BLDG 11-2, PHILA., PA 19112.

* SEE LIST A FOR FORMS  CODE ADDRESSES
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SAMPLE

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PHILADELPHIA AREA OFFICE           FEDERAL JOB OPPORTUNITIES LISTING
 (PA 001)                          PERIOD BEGINNING:  06/03/91                    PAGE   2
*******************************************************************************************
        JOB TITLE                      GRADE    FILING PERIOD       JOB        VACAN-   FORMS  CONTROL
                                       LEVEL    OPEN     CLOSE    LOCATION     CIES     CODE   NUMBER
*******************************************************************************************

BUSINESS, FINANCE & MGMT. OCCUPATIONS  GS-05/07 11/23/90- INDEF  NATIONWIDE    MANY     AA3*    PH2151
                      REMARKS:  THIS IS PART OF THE ADMINISTRATIVE CAREERS WITH AMERICA EXAMINATIONS.
                                A WRITTEN TEST IS REQUIRED. FILE OPM FORM 5000AB FOR ANNOUNCEMENT
                                #0001-B. FOR FURTHER INFORMATION OR TO OBTAIN APPLICATION FORMS
                                CONTACT ANY OPM JOB INFORMATION OFFICE OR CALL THE COLLEGE HOTLINE AT
                                1-900-990-9200. THIS IS A TOLL CALL CHARGED TO YOU AT $.40 A MINUTE

CARPENTER                              WG-09    06/03/91-06/28/91 VALLEY FORGE PA  FEW  PH0*    PH2289
                      REMARKS:  JOB SERIES 4607. LOCATION CODE 029 ONLY. $11.69 PER HOUR. FILE FORMS
                                SF-171; OPM 1203-AH; & PH:A0:99 (2/85).

CLERICAL & ADMIN. SUPPORT              GS-02/04 03/01/88- INDEF  ALL LOCATIONS  MANY    PH0*    PH0017
                      REMARKS:  MOST JOB OPENINGS ARE FOR CLERK-TYPIST; CLERK-STENO (INCL. GS-5); &
                                SECRETARY. WRITTEN TEST REQUIRED. FILE FORM 5000E. MANY AGENCIES IN
                                SOUTHEASTERN PA AREA HAVE DIRECT HIRE AUTHORITY FOR TYPIST & STENO
                                POSITIONS. ONCE YOU PASS THE TST YOU MAY APPLY DIRECTLY TO THESE
                                AGENCIES. MORE INFO WILL BE PROVIDED WITH YOUR NOTICE OF RESULTS.

CLERK                                  GS-02/03 08/16/90-07/31/91 NORTHEAST PHILA MANY (SEE REMARKS) PH2070
                      REMARKS:  THESE ARE CAREER-CONDITIONAL SEASONAL POSITIONS . SEASONAL EMPLOYEES
                                WORK PART OF THE YEAR, YEAR AFTER YEAR. MANY VACANCIES ARE NIGHT
                                SHIFT. WRITTEN TEST REQUIRED. TO APPLY CALL THE IRS DEU AT
                                (215) 698-4716.

CLERK-TYPIST, CLERK-STENO, ETC.        GS-02/04 04/01/91- INDEF  NORTHEAST PHILA MANY (SEE REMARKS) PH2248
                      REMARKS:  POSITIONS WILL BE FILLED ON A CAREER-CONDITIONAL SEASONAL OR INTERMIT-
                                TENT BASIS W/IRS, 11601 ROOSEVELT BLVD. MOST POSITION ARE FULL-TIME
                                DAY SHIFT. NIGHT SHIFT POSITIONS MAY BE AVAILABLE. IF YOU NEED ADDI-
                                TIONAL INFO. PLEASE CALL THE IRS DELEGATE EXAM UNIT (215) 698-4716.
                                ANNOUNCEMENT NO. IRS-1-91.

CYTOLOGIST                             GS-09    04/01/91-06/30/91 FT MEADE, MD       1      P20*    PB2186
                      REMARKS:  APPLICATIONS SHOULD BE SENT TO: WALTER REED ARMY MEDICAL CENTER,
                                CIVILIAN PERSONNEL OFFICE, RECRUITMENT & PLACEMENT DIVISION,
                                BUILDING 11, ROOM 2-91, WASHINGTON, D.C. 20307-5001
                                ATTN: LINDA SPOTTSWOOD.

DATA TRANSCRIBER                       GS-02/03 08/16/90-07/31/91 NORTHEAST PHILA MANY (SEE REMARKS) PH2069
                      REMARKS:  THESE ARE CAREER-CONDITIONAL SEASONAL POSITIONS. SEASONAL EMPLOYEES
                                WORK PART OF THE YEAR, YEAR AFTER YEAR. OPPORTUNITIES ARE BEST FOR
                                DATA TRANSCRIBER. TYPING ABILITY IS REQUIRED. MANY VACANCIES ARE NIGHT
                                SHIFT. WRITTEN TEST REQUIRED. TO APPLY CALL THE IRS DEU AT
                                (215) 698-4716.

ELECTRICIAN                            WG-10    05/16/91-06/14/91 WILKES-BARRE PA  FEW  PH0*    PH2294
                      REMARKS:  JOB SERIES 2805. LOCATION CODE 042 ONLY. $10.56 PER HOUR. FILE FORMS
                                SF-171; OPM 1203-AH; & PH:A0:225 (7/87)


* SEE LIST A FOR FORMS  CODE ADDRESSES
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COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF LABOR AND INDUSTRY

OFFICE OF VOCATIONAL REHABILITATION

217 PITTSBURGH STATE OFFICE BUILDING
300 LIBERTY AVENUE
PITTSBURGH, PENNSYLVANIA 15222

CERTIFICATION FOR SCHEDULED B EXCEPTED SERVICE
213.3202 (k)

TO:

FROM: Office of Vocational Rehabilitation

This is to certify that at present, mental health treatment and vocational rehabilitation have progressed to the stage where there are reasonable expectations that ______________ ____________________ is capable of functioning in the Federal position of _________________________ and related positions, and that any residual disability is not likely to interfere with performance on the job.

We further verify that ______________________________ has documented history of mental illness which includes periods of hospitalization and/or outpatient treatment within the previous two years, and is either currently unemployed as a result of the illness or had a significant period (at least thirty consecutive days) of substantially disrupted employment within the past two years because of this mental illness, or else, had his education or training disrupted or terminated due to mental illness.

_____________________________   _____________________________
REHABILITATION COUNSELOR   PSYCHIATRIST OR PSYCHOLOGIST

It is understood that I must also meet qualifications (education, experience, and/or training) for this position, and that in some instances, the hiring agency may require passing a non-competitively given test.

It is also understood that this appointment is for a maximum of two years and that continued Federal employment will then be subject to appointment through competitive examination procedures. This special two-year employment authority was established by the Federal government to allow individuals who have had significant psychiatric problems, which disadvantaged them, the opportunity to update their skills and establish a successful performance record. This is part of the selective placement and equal employment opportunity program.

____
Applicant's Signature

Subchapter 6: Employment of the Mentally Restored Persons

6–1. DEFINITION

A mentally restored person is one who has experienced some mental or emotional difficulty, has received professional treatment either in or outside of an institution and has been judged by competent medical authority as ready to resume normal activities including employment.

6–2. JOB RESTRICTIONS

As a general rule, a history of mental illness is not disqualifying for Federal employment provided that the applicant's status has been certified by competent medical authority and the applicant is capable of performing the duties of the position. However, there are some exceptions, such as when the illness may have a continuing effect on employment, e.g.:

(1) *Security.* Executive Order 10450, as amended, requires investigations of histories of mental illness because of the required disqualification for certain jobs when it is found that there has been "any illness, including any mental condition, of a nature which in the opinion of competent medical authority may cause significant defect in the judgment or reliability of the employee."

(2) *Other.* There are some types of positions for which applicants are screened carefully for emotional stability and maturity. These may involve unusual responsibility, overseas assignments, or other especially demanding requirements.

6–3. APPOINTMENT

a. **Competitive.** *Appointment Procedure.* Many mentally restored applicants are able to compete successfully in Civil Service examinations and to establish eligibility in keeping with their backgrounds of education and work experience.

b. **Temporary.** *Appointment Procedure.* In order to provide the mentally restored person an opportunity to demonstrate job readiness without requiring a firm commitment on the part of the employer, OPM has established a special procedure for a trial appointment using a temporary not to exceed 700-hours appointment authority (FPM chapter 316, section 4–6e). Once the employer is convinced that the employee can perform the duties of the position, the person may, if eligible be hired competitively, or reinstated, or converted to the accepted service under a Schedule B, section 213.3202 (k) appointment.

c. **Excepted.** *Appointment Procedure.*

(1) *Introduction.* The excepted appointment authority in Section 213.3202(k) of Schedule B was developed to provide mentally restored persons with ample opportunity to update their skills and to establish a successful performance record to counteract prejudice on the part of the employers. Until more experience is gained, use of this appointing authority requires prior approval of the Office of Personnel Management.

(2) *Definitions.* (a) For the purposes of this appointing authority, "mentally restored individual" refers to a person who has been unable to work for a significant period of time due to psychiatric or emotional illness, has received or is participating in professional treatment either in or outside of an institution, but is currently able to function successfully in a position for which he/she qualifies.

(b) "Significant period of substantially disrupted employment" refers to any period of time after the onset of illness during which the individual is unable to work, provided that such period is at least 30 consecutive calendar days. The 30 day period may be waived by the Office of Personnel Management based on consideration of other factors including:

—a work history which shows a record of shorter duration of acute illness which prevents employment.

—a work history which shows periods of noncompetitive employment. For example, sheltered workshop experience may be viewed as noncompetitive and as part of a rehabilitation process. Work performed on a piece or commissionbasis may also be considered noncompetitive in nature.

—a work history which shows a record of short periods of employment due to frequent or recurring acute illness.

(3) *Eligibility.* (a) Under this authority mentally restored persons must meet the following conditions:

- have a documented history of mental illness which includes periods of hospitalization and/or outpatient treatment. Treatment must have been within the previous 2 years;
- be certified by either a State or VA vocational rehabilitation counselor as being capable of functioning in a specific position. Documentation for certification should include a statement by a psychologist or psychiatrist as to capability to function in a work setting;
- be currently unemployed as a result of the illness or have had a significant period of substantially disrupted employment within the previous 2 years.

(4) A person without a previous work history (summer employment excluded) is not eligible for employment under this authority unless he/she can demonstrate that his/her education or training was disrupted or terminated due to mental illness requiring hospitalization or extensive outpatient treatment.

(5) *Appointment Procedures*. (a) General. Appointments may be made under the usual rules governing Schedule B appointments. Employees must meet the minimum qualifications for the position and grade, including a written test, if required. No person appointed under this authority may serve for more than 24 consecutive months pursuant to this appointment. It is anticipated that persons hired under this authority will no longer be at a competitive disadvantage after 2 years on the job. Thus, they must compete for any future Federal appointment, or have reinstatement or other noncompetitive eligibility.

(b) Repeated Appointments. Persons who have been appointed under this authority may be reappointed for an additional 2 year appointment, provided that there is a break in service of at least 90 days as a result of mental illness, which is certified as resulting in the inability of the individual to work. Each appointment shall be limited to 2 years.

(c) Temporary Appointments not to exceed 700-hours. An agency initially may employ a mentally restored individual on a 700-hour trial appointment (see 6-3b, above) which then may be converted to a Schedule B appointment. In such cases the 2 year period for the Schedule B appointment includes time served in a temporary appointment.

(d) Mobility. Commencing 90 days after the effective appointment date, the agency may reassign or promote the employee. Such action shall not change the effective date upon which the appointment terminates.

(e) Other Appointments. Nothing in this section should be considered as restricting or in any way limiting the employment of mentally restored individual through reinstatement, or any other appropriate hiring authority.

(6) Retired persons serving under this appointment receive all benefits including Civil Service retirement.

(7) *Requests for approval*. Requests for approval of appointments under 5 CFR 213.3202 (k) are to be made, in Washington, D.C. metropolitan area, to the Director, Selective Placement Programs, Office of Affirmative Employment Programs; or, in the field to the director of the appropriate Office of Personnel Management region, attention: Affirmative Employment Program Manager.

(8) *Recordkeeping*. Any certificate issued under the authority by a State vocational rehabilitation or Veterans Administration counselor must be maintained in a medical folder, rather than in the mentally restored person's official personnel folder (OPF).

c. **Physical Examinations.** As a general rule, handicapped individuals will have their fitness for employment—initial assignments and, as necessary, position changes—determined through the use of SF 78, Certificate of Medical Examination, to make sure that their placements are proper, effective, and compatible with their impairments. Only those functional requirements and environmental factors applicable to the specific job are to be designated. The SF 177, Statement of Physical Ability for Light Duty Work, however, may be used when deemed proper and appropriate by the appointing officer. In either case, the personnel physician or designated medical officer (ch. 792, this part) will review the health qualification findings for the purpose of recommending employment where the abilities of the individual are predictive of successful performance in the position without hazard to the individual or others.

d. Written Tests. Where written tests are required by the Office of Personnel Management or approved for use by the Director, Office of Personnel and Labor Relations, appropriate arrangements will be made for applicants with physical impairments to demonstrate pertinent knowledges, skills, and abilities by testing methods adapted to their special needs and circumstances. This includes those who are blind, deaf, and all others who may have difficulties in taking an examination in the normal manner.

e. Placement Evaluations (ch. 300, this part). Special attention will be given to the 90-day placement followup and the probationary (trial) period certification as one means of ensuring that the handicapped employee is properly placed and has full opportunity to succeed. Should another assignment be indicated or if termination cannot be justifiably avoided, appropriate personnel action will be taken. (See ch. 302, par. 9, this part, for trial period requirements as well as separations during the trial period.)

7. REASSIGNMENT IN LIEU OF DISABILITY RETIREMENT

Employees who become handicapped as a result of work injuries, off-the-job accidents, or disease will be given full opportunity to continue employment in their present positions or, if possible, assigned to more suitable positions. If necessary, vocational rehabilitation services of public or private agencies, at no cost to the VA, will be utilized to every practical degree to prepare the handicapped employee for continued employment (For *reporting purposes,* care should be taken that the personnel records of employees *acquiring* a reportable handicap or becoming entitled to disability (Veteran) preference are properly updated to reflect the appropriate changes.)

8. SEVERELY PHYSICALLY HANDICAPPED

a. Field stations may appoint severely physically disabled veterans and other persons who are considered to be severely physically handicapped (see FPM ch. 306, sec. 4-2 and FPM ch. 213) using the 700-hour trial appointment procedure or the excepted appointment procedure under section 213.3102(u) of Schedule A without prior approval from the Office of Personnel Management. Individuals appointed under this authority may be converted noncompetitively after 2 years of successful performance to career-conditional appointments (or career, if appropriate) depending on the length of creditable service. (See FPM ch. 306.)

b. VA Regional Office Counseling Psychology and Medical Center Counseling Psychology Staffs will utilize the "Certification Procedure" (FPM ch. 306, sec. 4-2d) for placement of severely physically handicapped individuals to the maximum extent possible in order to effect 700-hour trial appointments or excepted appointments under section 213.3102(u) of Schedule A. Counseling Psychology Staffs and Station Coordinators will pursue such techniques as part-time and intermittent appointments, job restructuring, worksite modifications and elimination of architectural barriers to facilitate placement and employment of severally physically handicapped individuals.

9. THIRTY PERCENT COMPENSABLY DISABLED VETERANS

Under Civil Service Regulation 315.707 (formerly Civil Service Regulation 315.703d), a disabled veteran who has a compensable service-connected disability of 30 percent or more may be appointed under a noncompetitive appointment leading to conversion to career or career-conditional employment. (Details on this authority and other provisions for disabled veterans are found in ch. 307, this part.)

10. MENTALLY RESTORED

a. The employment of qualified mentally restored individuals will also receive positive consideration. Such consideration is consistent with our responsibility to provide treatment and rehabilitation for mentally ill veterans. Accordingly, appointing officers will work with medical officials concerned and with other appropriate officials to facilitate the suitable employment and utilization of these persons.

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[b.] Schedule B, section 213.3202(k). This excepted appointment authority was developed to provide mentally restored persons with ample opportunity to update their skills and to establish a successful performance record to counteract prejudice on the part of employers. To be eligible for appointment as a mentally restored individual, the person must be at a severe disadvantage in obtaining employment because of a psychiatric disability evidenced by hospitalization and/or outpatient treatment and have had a significant period of substantially disrupted employment because of the disability. In addition, the person must be certified to a specific position by a State vocational rehabilitation counselor or a VA psychologist (or a VA psychiatrist). (See FPM ch. 306.)

[c.] VA Regional Office Counseling Psychology and Medical Center Counseling Psychology Staffs will utilize the "Certification Procedure" (FPM ch. 306) for placement of mentally restored individuals to the maximum extent possible in order to effect excepted appointments under Schedule B, section 213.3202(k). Counseling Psychology Staffs and Station Coordinators will pursue such techniques as part-time and intermittent appointments, job restructuring or other reasonable accommodation to facilitate placement and employment of mentally restored individuals.

11. MENTALLY RETARDED

The VA has an agreement with the Office of Personnel Management that grants authority for VA appointing officers to employ mentally retarded persons under Schedule A, section 213.3102(t) authority as described in FPM chapter 306, subchapter 7. Practically every station in the VA has some positions involving routine and repetitive work that qualified, mentally retarded individuals can perform satisfactorily. Accordingly, appointing officers will seek out possible applicants from their State Vocational Rehabilitation Agency for employment consideration. Through careful and considered placement action, the employment of these persons can be mutually advantageous to the VA and the individual. Individuals appointed under this authority may be converted noncompetitively after 2 years of successful performance to career or career-conditional appointments depending on the length of creditable service. (See FPM ch. 306.)

12. REHABILITATED OFFENDERS

VA stations will participate in the employment of rehabilitated offenders to the extent feasible under section 213.3102(x) of Schedule A. In addition, field station Directors and the Director, Central Office Personnel Service, are authorized to enter into agreements with Federal and District of Columbia prisons to implement the work release program as described in FPM chapter 306, subchapter 8. A copy of each agreement will be forwarded through channels to the Director, Office of Personnel and Labor Relations (054).

13. OUTSTANDING HANDICAPPED FEDERAL EMPLOYEES OF THE YEAR

a. **General.** The Office of Personnel Management has an annual awards program to recognize 10 Outstanding Handicapped Federal Employees of the Year (FPM ch. 306, subch. 10. The Annual Awards Ceremony is held during the first full week in October to coincide with National Employ the Handicapped (NETH) Week. Field stations should review the progress and accomplishments of their handicapped employees and nominate an individual they believe deserving of consideration as a candidate for the VA's nominee for the Outstanding Handicapped Federal Employees of the Year. Field station nominees should receive particular recognition in connection with local NETH Week activities.

Appendix B—Continued

Mentally Restored	**Summer Aids (Handicapped)**	**Students (Handicapped)**	**Unpaid Work Experience**	**Unpaid Work Experience Disabled Veterans**
Schedule B, 5 CFR §213.3202(k)	*Schedule A, 5 CFR §213.3102(v),*	*Schedule A, 5 CFR §213.3102(w)*	*No appointing authority used (clients of state agency)*	*No appointing authority*
1. Certification from State vocational rehabilitation counselor or VA counselling psychologist. 2. Position Description.* 3. SF 171 4. Memo to OPM requesting approval. SPECIAL REQUIREMENT 1. All appointments other than for a 700-hour temporary appointment must be approved by OPM (FPM 316.706(e)). Requests outside the metropolitan D.C. area should be sent to the appropriate OPM regional office. Request for appointment within the metropolitan D.C. area should be forwarded to the Director, Selective Placement Programs, 1900 E Street, NW., Washington, D.C. 20415.	1. Statement of financial need and referral from State employment office or, 2. If mentally retarded certification from State vocational rehabilitation counsellor or if physically disabled and eligible for 213.3102(u) appointment, documentation establishing extent of disability. (Financial need waived in both cases.)	1. Documentation of academic status. 2. Documentation of financial need or 3. Certification from State vocational rehabilitation counselor if mentally retarded or documentation as to extent of physical disability meets criteria for appointment under Schedule A, section 213.3102(u). (Financial need waived in both cases.)	1. Written agreement between agency and State vocational rehabilitation counselor. 2. Processing similar to student volunteer.	Plan 1 1. Written agreement between host agency and VA. 2. Approval by OPM if training would change qualification standards of target position. Plan 2: Service Connected Disabled Veterans Only 1. Written agreement between host agency and VA. 2. Approval from OPM if training would modify qualification standards of target position or if training leads to noncompetitive conversion into a position.

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POST EMPLOYMENT/EDUCATIONAL PLACEMENT FOLLOW-ALONG

SOCIAL SECURITY ADMINISTRATION MANUAL

RED BOOK ON WORK INCENTIVES

A Summary Guide to Social Security and Supplemental Security Income Work Incentives for People With Disabilities

[illegible]

[illegible]

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INTRODUCTION TO WORK INCENTIVES FOR PEOPLE WITH DISABILITIES

INTRODUCTION TO WORK INCENTIVES FOR PEOPLE WITH DISABILITIES

Reason for this booklet

One of the Social Security Administration's highest priorities is to help beneficiaries with disabilities achieve a better and more independent lifestyle by helping them take advantage of employment opportunities. The President has stated, "We believe that all persons with disabilities must be fully integrated into mainstream society, so they can live fulfilling and rewarding lives. During our years in public office, we have compiled strong records of support for public and private initiatives to enhance the independence and productivity of persons with disabilities." We at Social Security take these words very seriously and intend to do our part to remove the barriers which exist that prevent this goal from being achieved.

The enactment of the Americans With Disabilities Act (ADA) is a major step in the continued progress toward full empowerment for people with disabilities. Our mission to encourage employment and productivity is in keeping with the mandate provided by the ADA and other significant legislation such as the Rehabilitation Act and the Developmental Disabilities Assistance and Bill of Rights Act.

This booklet was prepared to assist professionals in the public and private sectors who work with people with disabilities. Your role as counselor, educator, representative or advocate provides you with communication opportunities not directly available to Social Security staff. By becoming familiar with the work incentive provisions in this booklet, you can help people with disabilities and their families make important decisions about employment.

This booklet is a guide to help you understand our work incentives. It is not intended to be used in making determinations about eligibility or benefits in particular cases. A person who needs information on a particular case should contact the local Social Security office.

Background

The Social Security Administration directs two disability programs:

- Social Security Disability Insurance (SSDI); and
- Supplemental Security Income (SSI).

These programs are similar in many respects but also have important differences, some of which are explained later in this booklet.

Purpose of work incentives

The SSDI and SSI programs should not be viewed as exclusive and permanent sources of income to the person with disabilities. They should, in every case possible, be used as stepping stones to improving a person's economic condition.

Work incentives are intended to give beneficiaries the support they need to move from benefit dependency to self-sufficiency.

The work incentives explained in this booklet are designed to help people with disabilities enter or reenter the workforce by protecting their entitlement to cash payments and/or Medicaid or Medicare protection, until they can support themselves.

Organization of this booklet

Because some people receive both SSDI and SSI payments and others receive only SSDI or SSI, the information in this booklet is grouped into the following six sections:

- General SSDI and SSI program information;
- An overview of SSDI and SSI work incentives;
- Work incentives that apply to both programs;
- SSDI only work incentives;
- SSI only work incentives; and
- Special work incentives for beneficiaries who are blind.

To help you identify and apply each work incentive, the top right-hand corner of this page explaining each incentive is labeled to show the program(s) to which the incentive applies.

Replacement of previous publication

This booklet replaces and obsoletes all previous editions.

SSDI AND SSI PROGRAM INFORMATION

ELIGIBILITY REQUIREMENTS

This section gives basic information about the SSDI and SSI programs so you can better understand how the work incentives apply. The specific provisions cited here are not work incentives.

SSDI To be eligible for SSDI, a person must:

- Have worked and paid Social Security taxes (F.I.C.A.) for enough years to be covered under Social Security; some of the taxes must have been paid in recent years;
- Be considered medically disabled; and
- Not be working or working but earning less than the substantial gainful activity (SGA) level.

SSI To be eligible for SSI based on a medical condition, a person must:

- Have little or no income or resources (refer to the Glossary for definitions of income and resources);
- Be considered medically disabled; and
- Initially not be working or working but earning less than the SGA level. Once on the rolls, work activity does not affect a person's continuing eligibility.

Work activity does not affect initial or continuing eligibility for a person who is blind.

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HOW WE FIGURE PAYMENT AMOUNTS

SSDI

The SSDI payment amount is based on a worker's lifetime average earnings covered by Social Security. The payment amount may be reduced by workers' compensation payments (including Black Lung payments) and/or public disability benefits (e.g., certain state and civil service disability benefits). It is not affected by other income or resources.

SSI

The SSI payment amount is based on the amount of other income which the person receives, his or her living arrangement and the state in which he or she lives. The basic payment is known as the Federal Benefit Rate. The Federal Benefit Rate is adjusted each year to compensate for cost-of-living increases. Most states pay an additional amount known as a State supplement. The amount and qualifications for these supplements vary from state to state.

To figure the SSI payment amount, we add the Federal Benefit Rate and the State supplement and then subtract the person's countable income. (See page 35.) Countable income includes income received by the person or some income received by the person's spouse or parent(s). Once a child turns age 18, the parents' income and resources are no longer considered in determining the child's eligibility or payment amount.

Not all income that a person receives is counted. For example, any part of a scholarship or grant that is used to pay for tuition, books, fees or related educational expenses is not counted. The sections on work incentives explain some of the ways that income can be excluded.

WAITING PERIOD

SSDI

A worker who becomes disabled must wait 5 full calendar months after disability begins before receiving SSDI benefits.

No new waiting period is required, if a worker returns to the disability rolls within 5 years of leaving the rolls.

NOTE: Children, widows, and widowers are subject to different rules.

SSI

No waiting period is required before receiving SSI benefits.

MEDICARE QUALIFYING PERIOD–SSDI ONLY

What it is

The first 24 months of disability benefit entitlement is the waiting period for Medicare coverage. During this qualifying period for Medicare, an SSDI beneficiary may be eligible for health insurance through a former employer. The beneficiary should contact the employer for information about health insurance coverage.

How months are counted

One month is counted for each month of disability benefit entitlement.

When previous periods count

Months in previous periods of disability may be counted towards the 24-month Medicare qualifying period if the new disability begins:

- Within 60 months after the termination of the workers receiving disability benefits; or
- Within 84 months after the termination of disabled widows' or widowers' benefits or childhood disability benefits; or
- At any time if the current disabling impairment is the same as, or directly related to, the impairment which was the basis for the previous period of disability benefit entitlement. (This provision applies to beneficiaries whose prior period of entitlement to disability ended after February 29, 1988.)

SUBSTANTIAL GAINFUL ACTIVITY

What it is	SGA is the performance of significant and productive physical or mental work for pay or profit.
How much it is	The SGA level is average countable earnings over $500 per month for non-blind beneficiaries. (See page 45 for the blind SGA amount.) We will deduct from gross earnings the cost of items a person needs in order to work and the value of support a person needs on the job due to the impairment before we decide if work is SGA.
How it applies	
SSDI	It applies to SSDI in determining initial and continuing disability entitlement.
SSI	It applies to SSI only in determining initial eligibility for SSI disability payments. It does not apply to SSI beneficiaries who are blind.

WHEN WE REVIEW A DISABILITY CASE

How often reviews are done

We review a disability case periodically to see if a person's condition has medically improved or if he/she can perform SGA. The timing of these reviews is described below:

- When the original disabling condition is expected to improve, we review the case on or about the date the improvement is expected;
- When medical improvement is possible, we review the case after 3 years;
- When medical improvement is not expected, we review the case after 7 years;
- When we receive information that the person may have returned to work or appears to have improved, we review the case at the time we receive the information; or
- When an SSI recipient becomes eligible for benefits under section 1619 or when there are changes in the 1619 status, we review the case at the time of eligibility or change, but not more often than once a year.

If we find the person is no longer disabled because of medical improvement related to the ability to work, we stop benefits unless he or she is in a vocational rehabilitation program. (See "Continued Payment to Individuals Under a Vocational Rehabilitation Program" on page 24.)

OVERVIEW OF WORK INCENTIVES

OVERVIEW OF WORK INCENTIVES

How they help people

Most people with disabilities want to work. It is important for disability beneficiaries to understand that they can still receive benefits while they try to work. Anyone who represents or deals with working SSDI or SSI beneficiaries should encourage them to contact the Social Security Administration and ask about work incentives and how they can affect their benefits.

SSDI

Work incentives provide support over a period of years to allow the disability beneficiary to test the ability to work and gradually become self-supporting and independent. In general, a person has at least 4 years to test the ability to work, including full cash payments during the first 12 months and a period in which cash benefits can be started again without a new application. The person continues to have Medicare coverage during this time.

The SSDI work incentives are:

- Impairment-Related Work Expenses;
- Trial Work Period;
- Extended Period of Eligibility;
- Continuation of Medicare Coverage;
- Medicare for People With Disabilities Who Work; and
- Continued Payment Under a Vocational Rehabilitation Program.

Each work incentive is discussed in detail later in this booklet. While the above information gives you an idea of some of the support offered to SSDI beneficiaries who want to work, it is important to view all of the work incentives as a total package to fully appreciate the level of support offered to help people achieve their goal of greater economic independence.

SSI

Over 4.4 million Americans receive SSI because of a disability. Many of these people would like to work but are afraid that if they do, they will lose their SSI checks and Medicaid coverage. The SSI work incentives offer these people ways to continue receiving their SSI checks and/or Medicaid coverage while they work. Some of the incentives can increase their net income to help cover special expenses they may have in order to work, to train for a job or to set up their own business.

Once a person begins to receive SSI, work activity will not cause SSI to stop as long as the person is still disabled. Even if the person cannot receive SSI checks because of the amount of earnings, eligibility for Medicaid may continue indefinitely. In many cases, if a person loses his/her job or is unable to continue working, he/she can begin receiving checks again without filing a new application.

The SSI work incentives are:

- Impairment-Related Work Expenses;
- Earned Income Exclusion;
- Student Earned Income Exclusion;
- Blind Work Expenses;
- Plan for Achieving Self-Support (PASS);
- Property Essential to Self-Support;
- Section 1619 Work Incentives; and
- Continued Payment Under a Vocational Rehabilitation Program.

Each provision is discussed in detail later in this booklet. These incentives offer persons who receive SSI because of disability an opportunity to overcome some of the barriers that may have kept them from working.

SSDI AND SSI WORK INCENTIVES

IMPAIRMENT-RELATED WORK EXPENSES

What they are

The costs of certain impairment-related items and services that a person needs to work are deducted from gross earnings in figuring SGA, even if these items and services are also needed for non-work activities. The deductions can be made only if:

- The cost of the item or service is paid by the person with the disability; and
- The person has not been, and will not be, reimbursed for the expense.

How they are deducted

The amount a person pays towards the cost of the items and services is deducted from gross earnings. Only after these expenses are deducted is a determination made as to whether "countable earnings" represent SGA. Impairment-related work expenses may reduce earnings below the SGA level.

How they apply to SSI monthly payments

Impairment-related work expenses are also excluded from earned income in figuring an SSI beneficiary's monthly payment amount.

Who determines whether expenses are deducted

The Social Security Administration field office determines whether expenses may be deducted from earnings. In making this determination, the field office may:

- Request the beneficiary or the representative to verify the need for an impairment-related work expense (this may be done by telephone or in writing); and
- Ask a beneficiary or representative if:
  - The item/service is related to the impairment and is necessary to enable the person to perform his or her job;
  - The person is personally paying for this item/service (and to submit proof(s)); and
  - Some other source is paying for the item/service, and how long that funding will continue.

When expenses are deductible

Impairment-related work expenses are deductible for both SGA and SSI payment purposes when:

- The expense enables a person to work;
- The person, because of a severe physical or mental impairment, needs the item or service for which the expense is incurred in order to work;
- The cost is paid by the person with a disability and is not reimbursed by another source (e.g., Medicare, Medicaid, private insurance);
- The expense is "reasonable"--that is, it represents the standard charge for the item or service in the person's community;
- The expense (for SGA purposes) is paid in a month in which the person with a disability is or was working (occasionally, an impairment-related work expense may be used before the first or after the last month of work activity); and
- The expense (for SSI payment purposes) is paid in a month in which earned income is received or work is performed while the person used the impairment-related item or service. (In unusual situations, when the payment of an impairment-related work expense does not correspond to a work month, it may be possible to deduct it.)

EXAMPLES OF EXPENSES LIKELY AND NOT LIKELY TO BE DEDUCTIBLE

DEDUCTIBLE	NOT DEDUCTIBLE
1. Attendant Care Services	**1. Attendant Care Services**
a. Performed in the work setting.	**a.** Performed on non-workdays or involving shopping or general homemaking (e.g., cleaning, laundry, etc.).
b. Performed in the process of assisting in preparing for work, the trip to and from work and after work (e.g., bathing, dressing, cooking, eating, etc.).	**b.** Performed for someone in the family other than the beneficiary (e.g., babysitting).
c. Services which incidentally also benefit the family (e.g., meals shared by the individual and his/her family).	**c.** Services performed by a family member for a cash fee where the family member suffers no economic loss.
d. Services performed by a family member for a cash fee where the family member suffers an economic loss by reducing or terminating work in order to perform such services.	**d.** Services performed by a family member for payment "in-kind" (e.g., room and board) whether or not the family member suffers economic loss.

DEDUCTIBLE	NOT DEDUCTIBLE
2. Transportation Costs	**2. Transportation Costs**
a. The cost of structural or operational modifications to a vehicle which the person needs in order to drive to work, even if the vehicle is also used for non-work purposes.	**a.** The cost of a vehicle whether modified or not.
b. The cost of driver assistance or taxicabs where such special transportation is not generally required by unimpaired individuals in the community.	**b.** The cost of modification to a vehicle not directly related to the impairment or critical to the operation of the vehicle (e.g., paint or decor preferences).
c. Mileage expenses for an approved vehicle at a rate determined by the Social Security Administration and limited to travel related to employment.	**c.** The cost of travel related to obtaining medical items or services.

DEDUCTIBLE	NOT DEDUCTIBLE
3. Medical Devices	**3. Medical Devices**
a. Wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment and braces (arm, leg, neck, back, etc.).	**a.** Any device not used for a medical purpose.
4. Work-Related Equipment and Assistants	**4. Work-Related Equipment and Assistants**
a. One-handed typewriters, typing aids (e.g., page-turning devices), measuring instruments, reading aids for persons who have visual impairments, electronic visual aids, braille devices, telecommunications devices for people with hearing impairments and special work tools.	**a.** Any work-related device not paid for by the person with a disability or, in the case of a self-employed individual, equipment previously deducted as a business expense.
b. Expenses for a person who serves as a reader for a visually impaired person, expenses for an interpreter for a hearing impaired person and expenses for a job coach.	
5. Prosthesis	**5. Prosthesis**
a. Artificial hip and artificial replacement of an arm, leg or other parts of the body.	**a.** Any prosthetic device that is primarily for cosmetic purposes.

DEDUCTIBLE	NOT DEDUCTIBLE
6. Residential Modifications	**6. Residential Modifications**
a. Individual Employed Outside Home	**a. Individual Employed Outside Home**
(1) Modifications to the exterior of the house which permit access to the street or to transportation (e.g., exterior ramps, railings, pathways, etc.).	**(1)** Modifications to the house primarily intended to facilitate functioning in the home environment (e.g., enlargement of interior door frames, lowering of kitchen appliances and bathroom facilities, interior railings, stairway chairlift, etc.).
b. Individual Self-Employed at Home	**b. Individual Self-Employed at Home**
(1) Modifications made inside the home in order to create a work space to accommodate an impairment (e.g., enlargement of a doorway leading into an office or workroom, the modification of office space to accommodate problems in dexterity, etc.).	**(1)** Any modification expenses previously deducted as a business expense in determining SGA.

DEDUCTIBLE	NOT DEDUCTIBLE
7. Routine Drugs and Routine Medical Services	**7. Routine Drugs and Routine Medical Services**
a. Regularly prescribed medical treatment or therapy that is necessary to control a disabling condition (even if unsuccessful), such as anti-convulsant drugs or blood level monitoring; radiation treatment or chemotherapy; corrective surgery for spinal disorders; anti-depressant medication, etc. The physician's fee relating to these services is deductible.	**a.** Drugs and/or medical services used for only minor physical or mental problems (e.g., routine physical examinations, allergy treatment, dental examinations, optician services, etc.).
8. Diagnostic Procedures	**8. Diagnostic Procedures**
a. Objective of procedure must be related to the control, treatment or evaluation of a disabling condition (e.g., electroencephalograms, brain scans, etc.).	**a.** Procedures paid for by other sources (e.g., Vocational Rehabilitation Agency, Medicaid) or not related to a disabling condition (e.g., allergy testing).

DEDUCTIBLE	NOT DEDUCTIBLE
9. Non-Medical Appliances and Devices	**9. Non-Medical Appliances and Devices**
a. In unusual circumstances, when devices or appliances are essential for the control of a disabling condition either at home or in the work setting (e.g., an electric air cleaner for an individual with severe respiratory disease), and this need is verified by a physician.	**a.** Devices used at home or at the office which are not ordinarily for medical purposes (e.g., portable room heaters, air conditioners, dehumidifiers, humidifiers, etc.) and for which the individual has no verified medical work-related need.
10. Other Items and Services	**10. Other Items and Services**
a. Medical supplies of an expendable nature (e.g., incontinence pads, elastic stockings, catheters, etc.).	**a.** An exercise bicycle or other device used for physical fitness unless verified as necessary by a physician.
b. The cost of a guide dog including food, licenses and veterinary services.	

SUBSIDIES

What it is

A subsidy is support a person receives on the job which could result in more pay than the actual value of the services the person performs. We deduct the value of subsidies when we determine SGA. Subsidies do not reduce countable income for SSI.

How it applies

Some workers with disabilities are not yet able to do a job as well as non-impaired workers without receiving some form of subsidy or work support. Examples of subsidies are:

- Giving the worker with a disability more supervision than other workers doing the same or a similar job for the same pay; and/or
- Giving the worker with a disability fewer or simpler tasks to complete than other workers doing the same job for the same pay.

Only earnings that represent the real value of the work performed are used to determine if work is at the SGA level. If an employer has difficulty setting the real value of the work and/or the amount of the subsidy, the Social Security Administration will make a determination of the value of the work.

CONTINUED PAYMENT UNDER A VOCATIONAL REHABILITATION PROGRAM

To whom it applies

It applies to persons who are receiving SSDI or SSI benefits who improve medically and, therefore, are no longer considered disabled by the Social Security Administration.

What it does

SSDI and SSI benefits will continue if, at the time disability medically ceases:

- The person is actively participating in an approved state or (effective November 1, 1991) an approved non-state public or private vocational rehabilitation program; and
- Completion or continuation of the program is likely to enable the person to work permanently.

How long benefits continue

Cash payments and health insurance continue until the rehabilitation services are completed or until the person ceases to participate in the program.

Who makes the decision

The Social Security Administration, with the aid of vocational rehabilitation information, determines eligibility for continued payments, based on the criterion that the person's participation in the vocational rehabilitation program will increase the likelihood of permanent self-sufficiency and independence from the disability rolls.

SSDI WORK INCENTIVES

TRIAL WORK PERIOD

How it helps people

Many people with disabilities would like to work but are afraid to try because of concern that their benefits might stop. The trial work period lets people test their ability to work or run a business for at least 9 months in spite of their disability, without affecting their disability benefits. They continue to get full benefits during the trial work period no matter how much they earn.

When it begins

Entitlement to a trial work period begins with the month in which the worker with a disability becomes entitled to disability benefits or the month in which the application is filed, whichever is later. (A person is not entitled to a trial work period if he or she is not entitled to disability benefits. A person is not entitled to disability benefits if he or she performs SGA level work within 12 months of onset of the impairment(s) which caused work to stop and before an award of disability benefits.)

What is counted as a trial work period month

Each month in which earnings are more than $200 (or over $200 in net earnings or more than 40 hours of work in a month for the self-employed) is counted as a month of the trial work period. When the beneficiary has accumulated 9 such months (not necessarily consecutive) within a 60-month rolling period, the trial work period is completed.

Effective January 1, 1992:

- A person will not use up his/her trial work period unless the 9 trial work months are completed within a rolling 60-month period; and
- A person will get a new trial work period every time he/she becomes reentitled to a new period of disability based on a new application.

What happens after it is completed

After the trial work period, the Social Security Administration reviews the work. SGA earnings during or after the trial work period normally indicate that the beneficiary is able to work in spite of a disabling impairment (see page 9 for a discussion of SGA):

- If the work is not SGA, SSDI benefits continue; or
- If the work is SGA, cash benefits continue for 3 more months (this is known as the "grace period"), then they stop. The person is now in the extended period of eligibility.

EXTENDED PERIOD OF ELIGIBILITY

What it is

The extended period of eligibility is a consecutive 36-month period during which cash benefits will be reinstated for any month the person does not work at the SGA level. Benefit checks can be started again without a new application, disability determination or waiting period. This reinstatement of benefits saves critical time for the beneficiary and replaces the loss of earnings.

When it begins

The extended period of eligibility begins the month following the end of the trial work period.

NOTE: Benefits can be reinstated within the 36-month period. However, benefits may be paid for an even longer period of time if a person is unable to perform SGA.

How it helps people

The extended period of eligibility reassures the beneficiary that disability benefits can be paid after the trial work period if he/she is unable to perform SGA anytime during the 36 months.

EXAMPLES

Example 1

Mr. Ray has been working at the local toy factory despite his arthritis. His 9th month of trial work was December 1987. The field office evaluated his work and found that he was performing SGA; eligibility for disability payments ceased in January 1988. He continued to earn above the SGA level through April 1988. (During this period, the Disability Determination Services made a medical severity determination and decided that Mr. Ray's impairment was still disabling.)

After Easter, orders dropped off and Mr. Ray was laid off. The field office found that he did not perform SGA in May 1988 through August 1988 (inclusive).

With the development of the Turnip Patch Doll, orders picked up, and Mr. Ray went back to full-time work. He performed SGA from September 1988 through December 1988 (inclusive).

Mr. Ray's arthritis got worse, and from January 1989 through April 1989 (inclusive) he worked part-time, not performing SGA.

In May 1989, feeling better, he went back to full-time work. His earnings have been above the SGA level ever since.

Question: What was the first month of his extended period of eligibility?

Answer: January 1988 (the first month immediately following the completion of the 9th month of trial work).

Question: If Mr. Ray's earnings continue to be above the SGA level, what will be the last month of his extended period of eligibility?

Answer: December 1990 (the month before the first month of SGA after the 36th month).

Question: What were the extended period of eligibility months for which he could potentially be paid?

Answer: January 1988, February 1988, March 1988 (the grace period), May 1988 through August 1988 and January 1989 through April 1989 (non-SGA months).

Example 2

Mrs. Bell began receiving SSDI benefits in January 1982. She returned to work in April 1986. Her trial work period ended in December 1986. In January 1987, the field office evaluated her work and determined it not to be SGA and disability payments continued.

Mrs. Bell continued to work at the non-SGA level until August 31, 1990. She then obtained a new position in which she earned above the SGA level. In October 1990, the field office made a determination that based on her work activity she no longer was eligible for disability payments as of September 1990.

Question: What was the first month of her extended period of eligibility?

Answer: January 1987 (the first month immediately following the completion of the 9th trial work service month).

Question: What is the last month of her extended period of eligibility?

Answer: November 1990 (the second month following the month in which the person's eligibility for disability payments ceases because of work activity).

Question: What are the extended period of eligibility months for which she could potentially be paid?

Answer: January 1987 through November 1990; i.e., all non-SGA months during the extended period of eligibility as well as the month of cessation and the following 2 months (grace period). The extended period of eligibility would terminate effective December 1990.

CONTINUATION OF MEDICARE COVERAGE

What it does

SSDI beneficiaries can receive at least 39 months of hospital and medical insurance after the trial work period. This provision allows health insurance to continue when a person goes to work and is engaging in SGA.

How it helps people

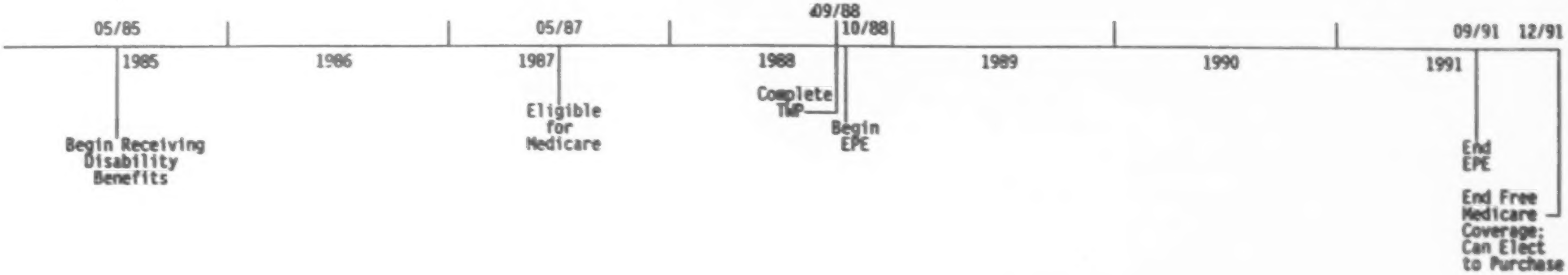
Although cash benefits may cease due to work, the beneficiary has the assurance of continued health insurance.

EXAMPLES

Example 1

John Smith had been entitled to Medicare since May 1987, his 25th month of disability insurance entitlement. Although he continued to have a severe impairment, he completed a trial work period on September 30, 1988 (his 9th trial work period month). If he continues working over the SGA level ($500 a month) throughout the extended period of eligibility (the 36-month period after the trial work period ends), his entitlement will continue through September 30, 1991. His Medicare will continue through December 31, 1991 (39 months after the trial work period ends), unless he medically recovers prior to that time.

The time line below depicts the major events in John Smith's Medicare coverage. Other work incentives must be reviewed in order to understand the total support offered to him.

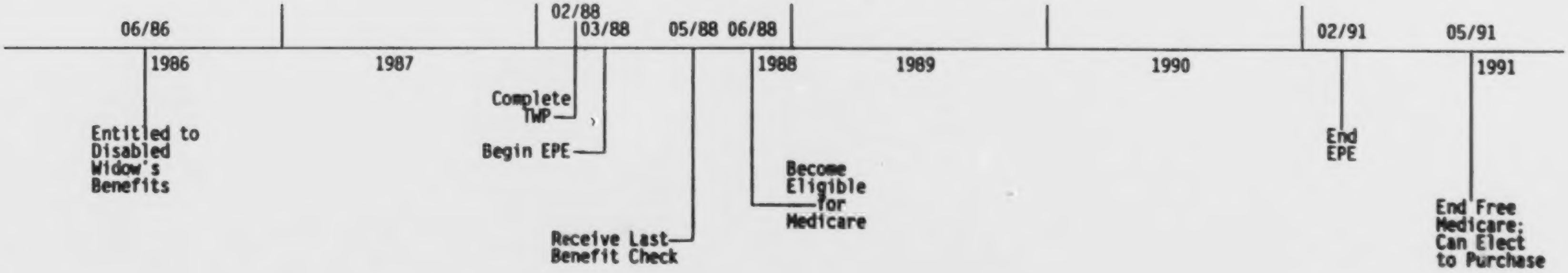

05/85
05/87
09/88
10/88
09/91
12/91
1985
1986
1987
1988
1989
1990
1991
Begin Receiving Disability Benefits
Eligible for Medicare
Complete TWP
Begin EPE
End EPE
End Free Medicare Coverage: Can Elect to Purchase

Example 2

Mary Jackson was entitled to disabled widows benefits beginning June 1986. She completed a trial work period February 1988. If she continues to engage in SGA, her extended period of eligibility will end February 1991 (36 months after the trial work period ended). Although she had only served 21 months of her Medicare waiting period (24 months are required) by the time she completed her trial work period, her disabled widow's benefit entitlement will continue for 36 months during her extended period of eligibility. The months in the extended period of eligibility will continue to count toward her Medicare qualifying period.

Thus, her Medicare coverage will begin June 1988, the fourth month of her extended period of eligibility. If her medical condition remains disabling, Mrs. Jackson's Medicare entitlement will end in May 1991, 3 months after her extended period of eligibility ends. As can be seen from the time line below, Mrs. Jackson received her Medicare benefits due to the extended period of eligibility work incentives. Mrs. Jackson continues to receive the support she needs in her work attempt.

The time line below depicts Mary Jackson's Medicare coverage and the work incentives support she received (trial work period and extended period of eligibility).


06/86
02/88
03/88
05/88
06/88
02/91
05/91
1986
1987
1988
1989
1990
1991
Entitled to Disabled Widow's Benefits
Complete TWP
Begin EPE
Receive Last Benefit Check
Become Eligible for Medicare
End EPE
End Free Medicare; Can Elect to Purchase

MEDICARE FOR PEOPLE WITH DISABILITIES WHO WORK

What it is

Certain people who have returned to work may purchase continued Medicare coverage, after premium-free Medicare coverage ends, due to work as long as he/she remains medically disabled. If the person becomes medically disabled again within 5 years (7 years for widow(ers) and disabled adult children) after the prior period of disability ends, he/she does not have to serve another 5-month waiting period to get benefits or Medicare.

Who is eligible

Anyone who:

- Is not yet 65; and
- Continues to have a disabling impairment; and
- Whose Medicare stopped due to work.

The kind of Medicare that can be purchased

- Premium Hospital Insurance (HI Part A) can be purchased at the same monthly cost which uninsured eligible retired beneficiaries pay;
- Premium Supplemental Medical Insurance (SMI Part B) can be purchased at the same monthly cost which uninsured eligible retired beneficiaries pay; or
- Hospital Insurance can be purchased separately without Supplemental Medical Insurance, but Supplemental Medical Insurance can only be purchased if Hospital Insurance is also purchased.

The enrollment period

An individual may enroll:

- During his or her initial enrollment period;
- During the annual general enrollment period (January 1 thru March 31 of each year); or
- During a special enrollment period if covered under an employer group health plan.

When the state pays premiums

States are required to pay Hospital Insurance premiums for qualified working individuals with disabilities. Qualified individuals are those who:

- Are eligible to enroll in premium Hospital Insurance for people with disabilities who work;
- Meet certain income and resource standards; and
- Are ineligible for Medicare on any other basis.

NOTE: Workers who are disabled should contact their respective State agency for information.

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SSI WORK INCENTIVES

EARNED INCOME EXCLUSION

What it does

This provision allows most of a person's earned income, including pay received in a sheltered workshop or work activities center, to be excluded when figuring the SSI payment amount. The Social Security Administration excludes the first $65 of earnings in a month plus one-half of the remainder. This means that less than one-half of a person's earnings are counted when figuring his/her SSI payment amount. This exclusion is applied in addition to the $20 general income exclusion.

Examples

The following examples show how the earned income exclusion is advantageous to the beneficiary. In Example 1, the person receives $161 SSDI each month; in Example 2, the person receives wages of $161 per month.

EXAMPLE 1

$161	(SSDI)
-20	(General income exclusion)
$141	(Countable income)

$446	(1994 Federal Benefit Rate)
-141	(Countable income)
$305	(SSI payment)

AVAILABLE INCOME

$161	(SSDI)
+305	(SSI)
$466	(Total income)

EXAMPLE 2

$161	(Earned income)
-20	(General income exclusion)
$141	
-65	($65 earned income exclusion)
$ 76	
÷2	(1/2 remaining earnings)
$ 38	(Countable income)

$446	(1994 Federal Benefit Rate)
-38	(Countable income)
$408	(SSI payment)

AVAILABLE INCOME

$161	(Earned income)
+408	(SSI)
$569	(Total income)

STUDENT EARNED INCOME EXCLUSION

What it does

It allows a person who is under age 22 and regularly attending school to exclude up to $400 of earned income per month. The maximum annual exclusion is $1,620.

Definition of "regularly attending school"

"Regularly attending school" means that the person takes one or more courses of study and attends classes:

- In a college or university for at least 8 hours a week; or
- In grades 7-12 for at least 12 hours a week; or
- In a training course to prepare for employment for at least 12 hours a week (15 hours a week if the course involves shop practice); or
- For less time than indicated above for reasons beyond the student's control, such as illness.

A person who is home taught because of a disability may be "regularly attending school" by:

- Studying a course or courses given by a school (grades 7-12), college, university or government agency; and
- Having a home visitor or tutor who directs the study.

How it is applied

The student earned income exclusion is applied before the general income exclusion or the earned income exclusion.

PLAN FOR ACHIEVING SELF-SUPPORT

What it does

A plan for achieving self-support (known as a PASS) allows a person with a disability to set aside income and/or resources for a specified period of time for a work goal. For example, a person could set aside money for an education, vocational training or starting a business. The plan can help a person establish or maintain SSI eligibility and can also increase the person's SSI payment amount.

A PASS does not affect an SGA determination for initial eligibility decisions. Income and resources that are set aside are excluded only under the SSI income and resources tests.

Who can have a plan

Any person who is blind or disabled who receives SSI or could qualify for SSI can have a plan. It is important to keep in mind that as earnings go up, the person who does not need a plan now may need one next month to remain eligible or to increase the SSI payment amount.

Requirements

The plan must:

- Be designed especially for the person;
- Be in writing;
- Have a specific work goal which the person is capable of performing;
- Have a specific timeframe for reaching the goal;
- Show what money and other resources received will be used to reach the goal;
- Show how the money and resources will be used;
- Show how the money set aside will be kept identifiable from other funds;
- Be approved by the Social Security Administration; and
- Be reviewed periodically to assure compliance.

Who may help set up a plan

Anyone may help the person with the plan, e.g., vocational counselors, social workers or employers. The Social Security Administration evaluates the plan and determines its acceptability. The Social Security Administration also helps people put their plans in writing.

How a plan is used to figure SSI eligibility and/or payment amount

Resources set aside under a plan are not counted towards the $2,000 resource limit. If income is set aside under a plan, it is excluded in the same way as blind work expenses, i.e., after all other applicable exclusions are applied. (See example under Blind Work Expenses on page 47.)

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2217

PROPERTY ESSENTIAL TO SELF-SUPPORT

What it does

This provision allows a person to exclude certain resources which are essential to the person's means of self-support.

How it works

Property which is used in a trade or business or used by a person for work as an employee is totally excluded as of May 1, 1990. For example, the value of tools or equipment which a person needs for work is totally excluded. For periods prior to May 1, 1990, the total exclusion only applied to property which was required by an employer.

Up to $6,000 of equity value of non-business property which is used to produce goods or services essential to daily activities is excluded (e.g., land used to produce vegetables or livestock solely for consumption by the person's own household).

Also, up to $6,000 of equity value of non-business income-producing property is excluded provided that the property yields an annual rate of return of at least 6 percent. This $6,000/6 percent rule also applies to property used in a trade or business for periods prior to May 1, 1990.

SECTION 1619 WORK INCENTIVES

Special SSI Payments for People Who Work (Section 1619(a))

What it does

This incentive allows SSI beneficiaries to receive SSI cash payments even when earned income (gross wages and/or net earnings from self-employment) exceeds the SGA level.

NOTE: It does not apply to SSI beneficiaries who are blind because the SGA requirement has never applied to them.

Requirements to qualify

To qualify for this incentive, the person must:

- Be eligible for an SSI payment for at least 1 month before he/she begins working at the SGA level;
- Still be disabled; and
- Meet all other eligibility rules, including the income and resource tests.

How it applies

People who have earnings above the SGA level can continue to receive SSI cash payments as long as they are still disabled and meet all other eligibility requirements. The person's payment amount will be calculated in the same way as for someone who is not working at the SGA level. (See earned income exclusion Example 2. on page 35.) The person will remain eligible for Medicaid.

Continued Medicaid Eligibility (Section 1619(b))

What it does

This incentive continues Medicaid coverage for most working SSI beneficiaries under age 65 when their earnings become too high to allow an SSI cash payment.

NOTE: Effective May 1, 1991, a person age 65 or over who is blind or disabled may qualify for continued Medicaid coverage under section 1619(b).

Requirements to qualify

To qualify for this incentive, a person must:

- Have been eligible for an SSI cash payment for at least 1 month;
- Still meet the disability requirement;
- Still meet all other non-disability requirements;
- Need Medicaid in order to work; and
- Have gross earned income which is insufficient to replace SSI, Medicaid and any publicly funded attendant care.

The Social Security Administration uses a threshold to measure whether a person's earnings are high enough to replace his/her SSI and Medicaid benefits.

What is the threshold?

The threshold amount is based on:

- The amount of earnings which would cause SSI cash payments to stop in the person's state; and
- The annual per capita Medicaid expenditure for the state.

If the person's gross earnings are higher than the threshold amount for his/her state, the Social Security Administration can figure an individual threshold if the person has:

- Impairment-related work expenses (see pages 15-22);
- Blind work expenses (see pages 46-47);
- A plan to achieve self-support (see pages 37-38);
- Publicly funded attendant or personal care; or
- Medical expenses above the state per capita amount.

Continued Medicaid eligibility in certain states

The following states use their own definitions of eligibility for Medicaid purposes which differ from SSI eligibility criteria:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Virginia

People in these states will continue to be eligible for Medicaid under the section 1619(a & b) incentive as long as they were eligible for Medicaid in the month before they became eligible for section 1619.

Special Benefits for Section 1619 Recipients Who Enter a Medicaid Facility

What it does

This provision allows an individual who is eligible under section 1619 to receive an SSI cash benefit for up to 2 months while in a Medicaid facility or a public medical or psychiatric facility.

Medicaid facility

Usually when an SSI recipient enters a Medicaid facility (i.e., a facility where Medicaid pays more than 50 percent of the cost of care), the SSI payment is limited to $30 per month minus any countable income. However, if the person is eligible under section 1619, the benefit will be figured using the full Federal Benefit Rate (see page 35) for up to 2 months.

Public medical or psychiatric facility

Usually when an SSI recipient enters a public medical or psychiatric facility, he/she is not eligible to receive an SSI payment while in the facility. However, if the individual is eligible under section 1619, SSI cash benefits continue for up to 2 months. For this provision to apply, the facility must enter into an agreement with the Social Security Administration allowing the person to keep all of the SSI payment.

Reinstating Eligibility Without a New Application

What it does

This provision enables people to regain eligibility for SSI cash payments or continued Medicaid coverage after a period of ineligibility without filing a new application.

Cash payments

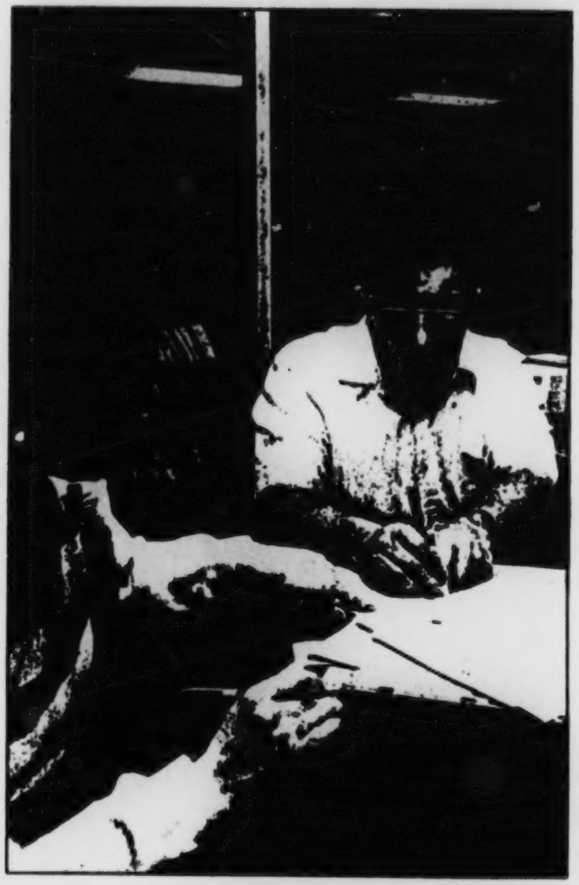
A person who is eligible for continued Medicaid coverage under section 1619(b) can begin receiving SSI cash payments at any time earnings drop below the break-even point. (See glossary for a definition of break-even point.)

A person who is ineligible for continued Medicaid coverage because earnings exceed the threshold can regain eligibility for SSI cash payments if income drops below the break-even point within 12 months.

Medicaid coverage

A person who is ineligible for continued Medicaid coverage because earnings exceed the threshold can regain eligibility for Medicaid coverage if earnings drop below the threshold within 12 months.

SPECIAL RULES FOR PEOPLE WHO ARE BLIND



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SPECIAL RULES FOR PEOPLE WHO ARE BLIND

How they help

Work incentives, in general, are special rules that help people, who are blind and people with other disabilities, return to work or work for the first time. Some of the rules apply only to people who are blind. These rules are designed specifically to make it easier for people who are blind to go to work.

NOTE: Blindness is defined as central visual acuity of 20/200 or less in the better eye with best correction which has lasted or is expected to last a year or longer.

HOW SGA IS APPLIED TO PERSONS WHO ARE BLIND

How SGA is applied to blind beneficiaries who work

The SGA level for beneficiaries who are blind changes each year to reflect changes in general wage levels. For example, in 1994 the SGA level for people who are blind is $930 per month. This amount is higher than the SGA level of $500 a month that applies to non-blind disabled workers.

How SGA is applied to self-employed beneficiaries who are blind

Self-employed persons who are blind are evaluated for SGA on the sole criterion of earnings. A separate evaluation of the time spent in the business is not made as it is for non-blind self-employed persons.

How SGA is applied to blind beneficiaries who are age 55 or older

After attaining age 55, if earnings exceed the SGA guidelines but the work done requires a lower level of skill and ability than that done before age 55, then benefits are only suspended, not terminated. Therefore, eligibility for Social Security benefits may continue indefinitely and benefits may be paid for any month earnings fall below SGA.

NOTE: Impairment-related work expense(s) deductions apply to blind SSDI beneficiaries who work.

BLIND WORK EXPENSES

What it does

Any earned income which a blind person uses to meet expenses needed to earn that income is not counted in determining SSI eligibility and the payment amount if the person is:

- Under age 65; or
- Age 65 or older and received SSI payments due to blindness (or received payments under a former state plan for aid to the blind) for the month before he or she attained age 65.

Because the blind work expenses work incentive is more advantageous, impairment-related work expenses do not apply to the blind SSI beneficiary who works.

NOTE: The expenses do not need to be related to the person's blindness.

Examples of blind work expenses

Some examples of blind work expenses are:

- Dog guide expenses;
- Transportation to and from work;
- Federal, state and local income taxes;
- Social Security taxes;
- Attendant care services;
- Visual and sensory aids;
- Translation of materials into braille;
- Professional association fees; and
- Union dues.

NOTE: The above listing is not all-inclusive.

How blind work expenses are used to figure SSI payments

Blind work expenses are used to reduce the amount of earnings which is counted when figuring the SSI payment amount. The following example shows how the blind work expense exclusion affects a person's SSI payments. This example uses the same circumstances as Example 2 under the SSI "Earned Income Exclusion," except this person also has blind work expenses of $40 per month.

EXAMPLE

$161	(Earned income)
-20	(General income exclusion)
$141	
-65	(Earned income exclusion)
$ 76	
÷2	(1/2 of remaining earned income)
$ 38	
-40	(Blind work expenses)
$ 0	(Countable income)

$446	(1994 Federal Benefit Rate)
-0	(Countable income)
$446	(SSI payment)

AVAILABLE INCOME

$161	(Earned income)
+446	(SSI)
$607	(Total income)

SPECIAL SERVICES PROVIDED

There are a number of services and products specifically designed to ensure that beneficiaries who are blind are informed of their rights and responsibilities under the Social Security programs.

Social Security letters

Letters and other correspondence can be received by certified mail, by telephone or in person by notifying the Social Security Administration.

Audio cassettes

The ***Red Book*** is available on a cassette tape. Also, available is the booklet "***If You Are Blind...How Social Security and SSI Can Help***."

Publications available in braille

The Social Security Administration offers the following related publications (including the ***Red Book***) in braille and are available upon request:

- Disability (Publication No. 05-10029);
- Supplemental Security Income (SSI) (Publication No. 05-11000);
- Medicare (Publication No. 05-10043);
- Understanding Social Security (Publication No. 05-10024)--A general but comprehensive overview of the Social Security program;
- Working While Disabled - How Social Security Can Help (Publication No. 05-10095)--A simple explanation of the work incentives under Social Security and SSI for beneficiaries who want to work;
- Working While Disabled (Publication No. 05-11017)--A guide to plans for achieving self-support (PASS) while receiving SSI;

- When You Get Social Security Disability Benefits - What You Need to Know (Publication No. 05-10153)--A guide to your rights and responsibilities while receiving Social Security disability benefits;
- When You Get SSI - What You Need to Know (Publication No. 05-11011)--A guide to your rights and responsibilities while receiving SSI; and
- If You Are Blind - How Social Security and SSI Can Help (Publication No. 05-10052)--A guide to the special work incentive rules that apply only to beneficiaries who are blind.

GLOSSARY

Blind Work Expenses (SSI)	Provides that any earned income of a person who is blind which is used to meet expenses reasonably attributable to earning the income is not counted in determining SSI eligibility and the payment amount.
Break-Even Point (SSI)	The dollar amount at which total income precludes SSI payment. As countable income increases, SSI payments decrease until the person is no longer eligible for any SSI payment. A person's break-even point varies with his/her earned/unearned income mix, applicable income exclusions and State supplement eligibility, if any.
Continuing Disability Review (SSDI and SSI)	The process of obtaining complete current information about the person's condition and any work activity to determine if the Social Security Administration should continue disability payments.
Countable Income (SSI)	The amount of money remaining after certain exclusions are deducted from total income--used in determining SSI eligibility and payment amounts.
Deeming (SSI)	The process of considering the income and resources of a parent or spouse to be the income and resources of the person who is applying for or receiving SSI benefits.
Extended Period of Eligibility (SSDI)	Permits the reinstatement of SSDI benefits, without a new application, disability determination or waiting period, to those people whose cash benefits were previously ceased because of SGA, if they discontinue SGA within 36 months following the trial work period. They must still meet the disability requirements.

Impairment-Related Work Expenses (SSDI and SSI)	Applies to all SSDI and those SSI beneficiaries who are not blind. Provides that the cost to the person with a disability of certain items and services related to the impairment and needed to work (e.g., attendant care services, medical devices, etc.) can be deducted from earnings in determining if the person is engaging in SGA. The items and services may also be needed for normal daily activities. These same impairment-related work expenses can be deducted, under certain circumstances, from earned income to determine an SSI beneficiary's countable earned income.
Income (SSI)	SSI income is: Earned income--money received from wages or self-employment earnings; unearned income--money received from other sources such as Social Security or Veteran's benefits pensions; in-kind income--free food, clothing or shelter; and deemed income--the portion of the income of a spouse or parent or sponsor of an alien which is used in computing the SSI payment amount. (In-kind and deemed income are types of unearned incomes.)
Medicaid (Medi-Cal in California) (SSI)	Medical coverage provided to a person by the state title XIX program.
Medical Improvement Expected (SSDI and SSI)	When a disability determination is made and it is determined that the disabling impairment may improve, the case is diaried for a future medical review (medical reexamination).
Medicare (SSDI)	Two-part health insurance program for eligible disabled and retired people: o Hospital Insurance under Medicare (HI Part A); and o Supplementary Medical Insurance under Medicare (SMI Part B).

Medicare for People With Disabilities Who Work (SSDI)	Allows certain people with disabilities who have returned to work to purchase continued Medicare coverage after premium-free Medicare ends due to work activity. The amount of the monthly premium will be the same as the premium amount charged uninsured people for Medicare hospital insurance and for medical insurance. States are required to pay hospital insurance premiums for qualified working individuals with disabilities.
Plan for Achieving Self-Support (SSI)	Applies only to the SSI program. Under a plan, a person is permitted to set aside income and/or resources over a reasonable period of time in order to obtain occupational training or education, purchase occupational equipment, establish a business, etc., thereby enabling the person to become financially self-supporting. The income and resources set aside under a plan are excluded from the SSI income and resource tests.
Property Essential to Self-Support (SSI)	Applies only to the SSI program. This provision allows full or partial exclusion of certain property necessary for self-support.
Resources (SSI)	Resources can be anything a person owns, such as a bank account, stocks, real property or personal property.
Substantial Gainful Activity (SSDI and SSI)	Performance of significant duties over a reasonable period of time in work for pay or profit (generally earnings averaging more than $500 per month for non-blind--both SSDI and SSI). The SGA level for beneficiaries who are blind changes each year to reflect changes in general wage levels. For example, in 1994 the SGA level for people who are blind is $930 per month.
SSDI	Used to denote title II Social Security Disability Insurance.
SSI	Used to denote title XVI Supplemental Security Income.
Trial Work Period (SSDI)	Begins with the month of entitlement; however, it cannot begin earlier than the month the application is filed. It ends after 9 months (not necessarily consecutive) of work for over $200 per month (or over $200 net earnings or over 40 hours of work per month if self-employed) by an SSDI beneficiary. For the 9 months to be accumulated, they must occur within a 60-month rolling period. The trial work period gives a beneficiary the opportunity to test work ability. A determination of the ability to perform SGA is not made until after the trial work period is completed.

ADDRESSES OF THE SOCIAL SECURITY ADMINISTRATION REGIONAL OFFICES

Boston Region I

Regional Commissioner, SSA
Attn: Disability Programs Branch
Room 1100
John F. Kennedy Federal Office Building
Cambridge Street
Boston, Massachusetts 02203

New York Region II

Regional Commissioner, SSA
Attn: Disability Programs Branch
Room 40-102, Federal Office Building
26 Federal Plaza
New York, New York 10278

Philadelphia Region III

Regional Commissioner, SSA
Attn: Disability Programs Branch
P.O. Box 8788
3535 Market Street
Philadelphia, Pennsylvania 19104

Atlanta Region IV

Regional Commissioner, SSA
Attn: Disability Programs Branch
Suite 1902
101 Marietta Tower
Atlanta, Georgia 30323

Chicago Region V

Regional Commissioner, SSA
Attn: Disability Programs Branch
10th Floor
600 West Madison
Chicago, Illinois 60661

Dallas Region VI

Regional Commissioner, SSA
Attn: Disability Programs Branch
Room 1440
1200 Main Tower Building
Dallas, Texas 75202

Kansas City Region VII

Regional Commissioner, SSA
Attn: Disability Programs Branch
Room 436, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Denver Region VIII

Regional Commissioner, SSA
Attn: Disability Programs Branch
Room 1194, Federal Office Building
1961 Stout Street
Denver, Colorado 80294

San Francisco Region IX

Regional Commissioner, SSA
Attn: Disability Programs Branch
75 Hawthorne Street
San Francisco, California 94105

Seattle Region X

Regional Commissioner, SSA
Attn: Disability Programs Branch
2201 Sixth Avenue M/S RX-53
Seattle, Washington 98121

QUESTIONS AND ANSWERS

ABOUT THE

SOCIAL SECURITY

WORK INCENTIVES

prepared by

The MATRIX ADVOCACY PROJECT

Matrix Research Institute
6008 Wayne Avenue
Philadelphia, PA 19144

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Fax: (215) 438-8337

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INTRODUCTION

This booklet focuses on the workings of two federally administered programs, both of which provide financial aid to individuals with disabilities. You apply to the Social Security Administration for benefits, and they will determine based on work history (among other disability related criteria) the benefit program(s) for which you are eligible.

The Supplemental Security Income (SSI) program is a federally-financed and administered program which provides a Minimum Income Level for individuals who are "aged", "blind" or "disabled", who have limited financial resources and little or no income. This essentially is a federal welfare program.

The SSI amount that you receive comes from federal and state money. The federal SSI monthly amount for 1994 is $446 for an individual and $669 for a couple. Pennsylvania, like approximately half of the states, adds a State funded supplement to this which brings the 1994 Pennsylvania SSI monthly maximum rate to $478.40 for an individual, and $717.70 for a couple.

Throughout this booklet the Pennsylvania SSI amounts are used. If you receive benefits in another state the amounts will be different, but the formulas used to figure deductions and reductions will remain the same. The rules governing the SSI and SSDI systems are federal rules and therefore are the same in every state. Some individual claims representatives may apply these rules more strictly than others. This booklet, however, explains the rules as they are written.

For people receiving Supplemental Security Income, please keep in mind that in order to remain eligible for benefits your resources (such as your bank account) must remain under $2000 for an individual and under $3000 for a couple. If your resources go over that amount in any month you will be charged with an overpayment, which means you will have to pay back the money you received in that month.

Social Security Disability Insurance (SSDI) on the other hand, is income from an insurance policy which you would have paid into while you were working as part of your Social Security payment. The amount that you would be eligible to receive in benefits is determined by the amount that you have paid in. With SSDI there is no resource limit, you may have any amount of money in the bank.

If the amount of SSDI for which you are eligible is less than the SSI maximum rate you may also receive SSI. The combination of the two checks will equal the SSI maximum rate.

GENERAL INFORMATION

SSI/SSDI

1. WHAT DO I NEED TO DO IF I GO TO WORK?

MOST IMPORTANT --> YOU MUST KEEP GOOD RECORDS

KEEP YOUR OWN RECORDS – Your Claims Representative at the Social Security Office keeps a file containing information about your benefits. IT IS EXTREMELY IMPORTANT THAT YOU ALSO KEEP RECORDS ABOUT: YOUR DISABILITY BENEFITS, YOUR JOB, WAGES YOU RECEIVE, WORK HOURS, WHEN YOU WORKED, AND WHERE YOU WORKED. Doing this will make it easier for you if there is ever a problem with your benefits.

- **KEEP ALL LETTERS AND NOTICES**
  - Open each letter or notice right away, read them carefully, and be sure to do whatever is asked of you by the deadline that appears in the letter.
  - If something in the letter or notice is confusing to you call either your claims representative, whose name and phone number should be in the upper right hand corner of letters or notices received from the local Social Security Office, or call The MATRIX ADVOCACY PROJECT (215) 438-8200.
  - Keep all letters and notices that you get from Social Security together in one envelope, folder, or box. Do not throw away any letters or notices, you may need to look at that information again at a later date.
- **KEEP COPIES OF EVERYTHING YOU SEND TO SOCIAL SECURITY.**
  - Whenever you write to the Social Security Office be sure to put your name, the date of the letter, and Social Security Number on each letter (and each page of the letter) and all forms.
  - Keep a copy of all letters that you send to Social Security.

- **KEEP A WRITTEN RECORD OF ALL PHONE CALLS YOU MAKE TO SOCIAL SECURITY.**

  Before making your call write down each of your questions to help you remember to ask them all.

  During, or right after the call write down
  - the date and time you called,
  - who you spoke to;
  - what you asked; and,
  - what you were told.

- **SOCIAL SECURITY HAS AN "800" NUMBER.**

  The Social Security Administration has an "800" telephone number 1-800-772-1213 which we would suggest that you use only for asking questions about Social Security policies or procedures.

  If you have a question about your specific case, or if you want to give Social Security information about your case, it is best to talk directly with your claims representative. The name and phone number of your claims representative should appear in the upper right hand corner of all letters that you receive from your local Social Security office.

  If you have any other questions about how SSI or SSDI works, about the meaning of a letter you have received, or about how working will impact your benefits, call The MATRIX ADVOCACY PROJECT between 9:00 a.m. and 5:00 p.m., Monday through Friday (215) 438-8200.

- **WHEN YOU GO TO WORK, ALWAYS KEEP YOUR PAY STUBS* --** You will need to show exactly how much you earned, where you worked, and when you worked.

  Social Security counts as "EARNED INCOME" all the checks/money you receive, in the month you received them, even if the money was earned the month before.

---

* If you do not have pay stubs, a letter from your employer on letterhead stating how much you earned for the month should be sent in at the end of each month.

Social Security counts the GROSS INCOME AMOUNT in each month; **the gross amount is the full amount of the check before taxes and other deductions are taken out**, not the Net Amount: the net amount is the amount of money you get when you cash the check.

You must take in or mail the **originals** (not photo copies) of all pay stubs to your Claims Representative at Social Security. These must be given to your claims representative at the end of each month (Social Security must receive them by the tenth day of the next month).

- Make sure that you keep copies of all pay stubs.

REMEMBER -- RESPOND QUICKLY TO ALL LETTERS FROM SOCIAL SECURITY WHEN THEY ARE ASKING YOU FOR INFORMATION, OR WHEN THEY ARE TELLING YOU THAT YOUR BENEFITS WILL BE CHANGED OR STOPPED. IF THE LETTER IS NOT CLEAR TO YOU, GET SOMEONE TO HELP YOU UNDERSTAND IT RIGHT AWAY!

SUPPLEMENTAL SECURITY INCOME (S S I)

IN ALL SITUATIONS WHERE THE SSI CHECK IS REDUCED DUE TO INCOME RECEIVED, THE CHECK EFFECTED WILL BE THE SECOND MONTH AFTER THE MONTH WHEN THE INCOME IS RECEIVED, (unless otherwise stated). THIS MEANS: IF YOU EARN MONEY IN *JANUARY* YOUR *MARCH* CHECK WILL BE EFFECTED.

2. WHAT IS UNEARNED INCOME AND HOW DOES IT AFFECT MY SSI CHECK?

- **UNEARNED INCOME is any money that you have received but did not work for, other than your SSI check.** This could include such things as:
  - Social Security Disability Insurance (SSDI)
  - Veterans Benefits
  - Unemployment Benefits
  - State Disability

- **The first $20 of unearned income received in any month will not reduce your SSI check at all, this is your "GENERAL DEDUCTION".**

- **Unearned income over $20 in any month reduces your SSI check by $1 for every $1 of unearned income you receive.**

Example #1: This person gets $305 a month from the Veterans Administration **(UNEARNED INCOME)**, his SSI check would be effected like this:

$305.00	(Unearned Income - VA Benefits)
- 20.00	(minus the twenty dollar "General Deduction")
$285.00	(equals "Countable Income")
$478.40	(Pennsylvania SSI maximum rate 1994)
-285.00	(minus the countable income figured above)
$193.40	(equals the SSI check amount for that month)

Keep in mind that since the check effected is two months later, if your income is not steady you must budget carefully. In the month you receive earnings you will have your SSI check and the income, but two months later you may only have the reduced SSI check.

SSI

3. WHAT IS EARNED INCOME AND HOW DOES IT AFFECT MY SSI CHECK?

- **EARNED INCOME is money you have received for working or from self-employment.** (This pay could be from work at your job or money earned at a workshop)

- Social Security counts your **GROSS EARNED INCOME**, which is your pay before any taxes or other deductions have been taken out

- Earnings are counted **in the month you are paid**, even if some or all of it was earned the month before

- **The first $65 of gross earned income will not reduce your SSI check, this is your "EARNED INCOME DEDUCTION".**

- **Gross earned income over $65 reduces the amount of your SSI check by $1 for every $2 of income** ($1 is subtracted from your check for every $2 you make over $65).

- **If you have no unearned income but you do have earned income,** the $20 General Deduction can then be added to the $65 Earned Income Deduction giving you an $85 total deduction.

  This means that the first $85 of gross earned income (before any taxes or other deductions are taken out) received in any month will not reduce your SSI check at all.

  Once you receive over $85 in gross earnings in a month, your check will begin to be reduced. It will be a $1 reduction in the amount of your check for every $2 of earnings over $85.

Example #2: This individual makes $305 in a month from a job **(EARNED INCOME)**, and has no unearned income. Her SSI check would be effected like this:

$305.00	(Earned Income - Wages)
- 85.00	(minus the total deduction, $20 + $65)
$220.00	
$220.00	
÷ 2	($1 reduction for each $2 in earnings)
$110.00	(equals "Countable Income")
$478.40	(Pennsylvania SSI maximum rate 1994)
-110.00	(minus the countable income figured above)
$368.40	(equals the SSI check for that month)

The check that will be effected is two months later so be very sure to budget your money properly so that you have enough money to pay your rent in two months.

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SSI

4. IF I RECEIVE BOTH UNEARNED AND EARNED INCOME IN THE SAME MONTH, HOW IS MY SSI CHECK EFFECTED?

- Countable Income has to be figured separately for unearned income (using the $20 General Deduction), then the earned income (using the $65 Earned Income Deduction), and then add the two figures.

Example #3 An individual receives $220 a month from Social Security Disability Insurance (which is UNEARNED INCOME), and makes $315 a month from a job (which is EARNED INCOME) his SSI check would be effected like this:

Step 1	-	$220.00	(Unearned Income - SSDI)
		- 20.00	(minus the twenty dollar General Deduction)
		$200.00	(equals "Countable Unearned Income")
Step 2	-	$315.00	(Earned Income - Wages)
		- 65.00	(minus the $65 Earned Income Deduction)
		$250.00	
		$250.00	(from above)
		÷ 2	($1 reduction for each $2 in earnings)
		$125.00	(equals the "Countable Earned Income")
Step 3	-	$200.00	(Countable Unearned Income)
		+125.00	(Countable Earned Income)
		$325.00	(Equals the Total Countable Income)
Step 4	-	$478.40	(Pennsylvania SSI maximum rate 1994)
		- 325.00	(minus the total countable income)
		$153.40	(equals the amount of the SSI check)

SSI

5. WHEN MUST I MAKE SOCIAL SECURITY AWARE OF MY INCOME?

- At the end of any month in which you have Unearned Income over $20, that Social Security does not already know about, you are to report it to your Claims Representative at Social Security. You will need to tell that person:
  - the source of the income, and
  - the amount of the income.

- If you make over $65 of Earned Income (gross wages) in any month (or over $85 if you also have Unearned Income), you should call your Social Security Claims Representative and tell them that you are working and you will send your pay stubs at the end of the month.
  - Originals of pay stubs should be taken in or mailed after the last payday of each month.
    - If your pay checks do not have a "stub" to send in, Social Security will accept a letter from your employer on the employer's letterhead which states your gross earnings for that month. This will have to be done each month.
  - Social Security must have the information on your wages by the 10th day of the following month.
  - The SSI check effected by your income will be the check received the second month following the month you received the earnings.
    - This means: If you have Earned Income over $85 in January, your March check will be the one effected.
  - Keeping your Claims Representative informed of all income will help you avoid an overpayment which you will have to pay back.

SSI

6. HOW MUCH CAN I MAKE BEFORE I STOP GETTING AN SSI CHECK?

- Your SSI check will continue to be reduced by $1 for every $2 you earn over $85 until your earnings reach what Social Security calls the **BREAKEVEN POINT**. At that time, you will no longer receive an SSI check. The Breakeven Point is calculated by reversing the formula used to figure deductions. The 1994 Pennsylvania Breakeven Point is figured as follows:

$ 478.40 = Full SSI check each month (Pennsylvania 1994)
x 2 ($2 for every $1 that would have been reduced)
$ 956.80
+ 65.00 = General Deduction + Earned Income Deduction
$1041.80 = 1994 PENNSYLVANIA BREAKEVEN POINT

- **If you have Unearned Income such as SSDI, or receive free room and board, the "Breakeven Point" for you will be lower.**

Example #4 This person received $120 in Unearned Income for the month which has reduced her SSI check to $378.40. She does not get the $20 General Deduction since this would have already been subtracted from the unearned income, so she gets only the $65 Earned Income Deduction. Her Breakeven Point would be calculated as follows:

$ 378.40 (SSI after Unearned Income reduction)
x 2
$ 756.80
+ 65.00 (Earned Income Deduction)
$ 821.80 (her Breakeven Point)

- **If your earnings reach or go over the Breakeven Point, it means you will stop getting your checks beginning the month of the earnings**, not two months ahead like the other deductions related to these work incentives.

- **As long as you continue to get at least a $1 SSI check, you will receive your full Medicaid benefits.** Medicaid is the medical coverage you receive, which in Pennsylvania is Medical Assistance, Health Pass, or an HMO which may be offered instead of Medical Assistance. The Medicaid program is administered by the State.

- See Sections 9 (on PASS) and 10 (on IRWE) below for descriptions of allowable deductions to lower your Countable Income.

7. DO I LOSE MY MEDICAID WHEN MY WAGES ARE OVER THE BREAKEVEN POINT AND I NO LONGER GET AN SSI CHECK?

- You do not necessarily lose your medical coverage when your income causes you to stop getting a check, you may be eligible for an SSI category called **1619(b)**.

- To be eligible for 1619(b) you must have stopped getting your SSI check due to earnings (you did not lose your check due to recovery from your disability or excess resources).

- In most cases, if you have Medicaid before going to work, you can keep your Medicaid after you earn over the Breakeven Point as long as:

  you continue to have a disability and need Medicaid in order to work, or,

  your employer does not offer medical coverage, or comparable medical coverage, or you cannot afford to pay for it; or,

  you have used your Medicaid in the past 12 months and will have a need to use it in the next 12 months.

- You are eligible for continued medical benefits under 1619(b) as long as you meet the above criteria, and your income is not more than $17,479.60/yearly (which is $1,464.10/month or $388.12/week). This is referred to as the Pennsylvania "THRESHOLD AMOUNT", each state has it's own Threshold Amount. If you have high medical costs a higher threshold may be set for you.

- **As long as you continue receiving your Medicaid, your SSI check will be started again any time your income drops below the Breakeven Point.**

This is called **REINSTATEMENT**, you will not have to apply again, just notify your Claims Representative at the end of each month about your income.

For Reinstatement to occur you must continue to notify your Claims Representative of your income at the end of each month.

SSI

8. WHAT HAPPENS IF MY SSI CHECK AND MEDICAID IS STOPPED DUE TO MY EARNINGS AND I GET SICK AND CAN NOT WORK?

- If within one year of your losing both your SSI check and Medicaid your gross earned income drops below the Breakeven Point or you have no income at all due to losing your job, Social Security will **reinstate** you. This means they will start your SSI check without you having to apply again.

- If you lose your job more than one year after all benefits have stopped, you will have to reapply for benefits through the same process you used when you first applied.

SSI

9. WHAT IS "P.A.S.S." AND HOW CAN IT HELP ME WITH MY VOCATIONAL GOALS?

- **P.A.S.S. -- Plan for Achieving Self-Support** -- is a way to put away income (other than your SSI check) to help you reach a vocational goal while not having that money be considered as countable income or resources.

- The purpose of a PASS plan is to help you move toward being financially self-sufficient by letting you put away money to help you achieve your vocational goal(s).

- PASS allows you to save income and/or resources for a vocational goal such as: education, vocational training, starting a business, buying tools, uniforms, transportation, hiring a job coach, etc.

- PASS plans must have a specific vocational goal that you are capable of reaching.

- PASS plans must be written and designed especially for you and your vocational goal(s).

- PASS plans must be approved by Social Security.

- PASS plans will be reviewed from time to time by Social Security, to see if you are doing what the PASS plan says you will do.

- PASS plans can reduce or eliminate countable income that would usually cause your SSI check to be reduced or stopped.

- PASS plans are first approved for 18 months. An 18 month extension may be granted if needed, and another extension of 12 months may be granted after that (for a total of 48 months maximum).

- PASS plans must show how the money and/or resources will be used.

- Money saved in a PASS is not counted as a resource even if it is over the $2000 limit for an individual.

- PASS money should be kept in a separate bank account so that the money saved in a PASS is easily identified as separate from other resources.

- When the PASS money is spent you must keep all receipts to show that the money was spent for those things approved in the PASS.

Example #5 This man has a PASS plan which says he will pay $100 a month to hire a job coach. This is what would happen

$ 285 00	(gross earned income)
- 85.00	(General and Earned Income Deductions)
$ 200 00	
÷ 2	
$ 100.00	(Countable Income before PASS)
-100.00	**(PASS deduction)**
$ 0.00	**(Countable Income)**

Because there is no countable income this person would receive his full SSI check. Note that the PASS deduction is from Countable Income, not from gross earnings.

SSI

10. HOW CAN MY DISABILITY-RELATED EXPENSES BE USED TO LOWER THE COUNTABLE INCOME THAT REDUCES MY SSI CHECK?

- I.R.W.E.'s -- Impairment Related Work Expenses -- are expenses that can be deducted from earned income to reduce the countable earned income that would otherwise reduce your SSI check.
- IRWE's apply to you if you pay for work related expenses, which due to your physical or mental disability are necessary in order for you to be able to work.
- Payments must be reasonable and paid by you in cash, checks, or money orders, and at the end of the month you send in the receipts to your Claims Representative.
- Only work related expenses which are not reimbursable from Medicaid, Vocational Rehabilitation, or other sources are usable under IRWE.
- There is no time limit on using an IRWE as long as it is needed in order to work. This means you can use IRWE's as long as you are receiving SSI and are working.
- IWRE's must be approved by Social Security.

Example #6: This person has an earned income of $285 this month and has Impairment Related Work Expenses of $100, this is how her SSI check would be effected:

$ 285.00	(gross earned income)
- 85.00	(general and earned income deductions)
$ 200.00	
-100.00	**(IRWE deduction)**
$ 100.00	
÷ 2	
$ 50.00	**(Countable Income)**

This person's SSI check would then be reduced by $50. Note that the deduction occurs before dividing by two, this is different from PASS. In effect this means that you get credit for one-half of your work related expenses.

SSI

11. WHAT HAPPENS TO MY SSI CHECK IF I HAVE TO GO INTO THE HOSPITAL FOR A MONTH OR MORE?

- If you go into the hospital and your doctor expects you to be in the hospital for a full calendar month or more **(all the days in a month)**, your Social Security Claims Representative at the local office must be contacted right away and they will need a letter from your doctor saying how long you are expected to be in the hospital.
- If you do this, you will continue to get your full SSI check for up to 2 months while you are in the hospital. This will help you to keep paying your rent.
  - After two months your check will be reduced to $30 a month until you come out of the hospital.
- If you do not notify Social Security your SSI check will be reduced to $30 for each full calendar month you are in the hospital.

- When you go into the hospital you are not likely to be thinking about notifying Social Security, therefore, it would be helpful to you if the people close to you know about this rule

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

SSDI HAS TOTALLY DIFFERENT WORK INCENTIVE RULES FROM SSI. WITH SSDI, THERE IS NO GRADUAL REDUCTION OF YOUR CHECK. YOU WILL EITHER GET YOUR ENTIRE SSDI CHECK OR NO CHECK AT ALL. HERE IS HOW IT WORKS :

SSDI

12. WHAT IS A TRIAL WORK PERIOD IN SSDI?

- On SSDI you are entitled to a **9-MONTH TRIAL WORK PERIOD** which allows you to return to work, and get re-adjusted to working while still receiving your entire SSDI check.

- The nine months of a Trial Work Period do not have to be in a row to be counted. They can be stretched out over time. You have nine months of trial work period available over a five year period.

  The computer will look back five years from the current month and count how many Trial Work Months have been used. It will do that every month by adding the current month and dropping the oldest month.

- After January of 1990, any month your gross earned income is $200 or more, that month will be counted as a trial work month. **(Before January 1990 any month when your gross earned income was $75 or more count as trial work month.)**

- Be aware of the fact that the amount of money you earn during the Trial Work Period, though it will not effect your check, will be one of the factors which will be used during a Disability Review to help determine if you are still disabled.

- During the trial work period, you will have the wages you have earned, your Medicare, and will continue to receive your SSDI check.

- After you have used your Nine Month Trial Work Period, Social Security will schedule you for a disability review, sometime within the next three months.

- If during this disability review, Social Security decides you are **no longer disabled**, you will receive 3 more months of SSDI checks **and** Medicare and then benefits will end. **(see question 19 on appeals)**

- If Social Security decides you are **still disabled** you get an EXTENDED PERIOD OF ELIGIBILITY.

SSDI

13. WHAT IS THE EXTENDED PERIOD OF ELIGIBILITY IN SSDI?

- The Extended Period Of Eligibility in SSDI begins immediately after you have completed your 9 months of trial work. It lasts for 36 consecutive months, whether you work or not.

- During this 36-month period, you will receive your full SSDI check for each month when your gross earned income is below **SUBSTANTIAL GAINFUL ACTIVITY (SGA)**.

  - Substantial Gainful Activity is most often considered to be $500.

  - On an individual basis, however, Substantial Gainful Activity can be set lower, if Social Security believes that you are keeping your income low just to avoid losing your SSDI.

- During the Extended Period of Eligibility when your monthly income is above $500, you will not receive your SSDI check.

The SSDI check which will be effected by this income will be the second month after the month in which the income was received. If you are in your Extended Period of Eligibility, and you earn $600 in January, you will not receive a March check.

If you earn under $500 in the next month you will then receive your check for that month.

- You keep your Medicare throughout your 36 month Extended Period of Eligibility, whether you are receiving a check or not.

- See Section 14 below for a deduction that may be used to reduce countable income and enable you to continue to get your SSDI check during the Extended Period Of Eligibility.

- **The first month after your 36-month Extended Period of Eligibility has ended when your gross earnings are over $500 (SGA), your SSDI ends.**

  This could be the first month after the Extended Period of Eligibility ends or the two-hundredth month.

  If you are again in a position where you cannot work, after you stop receiving benefits, and you are still considered disabled, you can re-apply for benefits.

  If you begin to receive SSDI again after re-application, you will have a new Nine Month Trial Work Period available to you.

SSDI

14. CAN I USE IMPAIRMENT-RELATED WORK EXPENSES WITH SSDI?

- I.R.W.E.'s -- Impairment Related Work Expenses -- are expenses that can be deducted from gross earnings to reduce countable income.

- IRWE's apply to you if you pay for work related expenses which are necessary due to your physical or mental disability in order for you to be able to work.

- You can use IRWE's to reduce the amount of gross earned income counted as long as what is being bought is needed for you to be able to work.

- IRWE's must be approved by the Social Security Office.

- Expenses must be reasonable and be paid by you in cash, checks, or money orders and then receipts submitted to your Claims Representative at the end of the month.

- Only work related expenses which are not reimbursable from Medicare, Vocational Rehabilitation, or other sources are usable under IRWE.

- IRWE's have two uses for people on SSDI:

  It can reduce countable income to under $200 in order to not use a trial work month; or,

  Keep income under $500 enabling you to continue to receive your SSDI check during your Extended Period Of Eligibility.

  Money is not reimbursed to you, the lowering of countable income is the only effect the IRWE will have.

- For people receiving SSDI, IRWE's are deducted 100% from gross earned income.

Example #7 : This person is on SSDI and in the Extended Period of Eligibility. This month she has an income of $585, and has $100 of Impairment Related Work Expenses. The SSDI check would be effected like this:

$ 585.00 (gross earned income)
- 100.00 (IRWE deduction)
$ 485.00 (Countable income)

Countable income is under $500, so she gets her full SSDI check

SSDI

15. WHAT IS EXTENDED MEDICARE?

- After you have completed your Extended Period of Eligibility, the next month that you gross over $500 you will no longer get your SSDI check, but you will get 3 more months of extended Medicare coverage.
- After that three month period, Medicare Buy-In allows you to buy Medicare coverage for a monthly premium, if you are under 65 and remain disabled.

ISSUES EFFECTING BOTH SSI and SSDI

SSI/SSDI

16. WILL WORKING RESULT IN A DISABILITY REVIEW?

- If you are getting SSI and start making $500 gross earned income or more, you are then in a category called 1619(a). The effect this will have on you is that Social Security will do a disability review on your case within 12 months.
- If you are getting SSDI a disability review will be done at the end of your Trial Work Period.
- **Even if you do not work Social Security will do periodic disability reviews of your case, for most people this will be every 3 to 4 years.**

SSI/SSDI

17. WHAT IF SOCIAL SECURITY SAYS I AM NO LONGER DISABLED?

- You can appeal the decision and if you are still receiving treatment or rehabilitation services you have a chance of the decision being overturned.
- If you are receiving vocational rehabilitation services and continuing to do so will improve your chances of employment and removal from SSI/SSDI, you may continue to receive your check under **Section 301**, even though Social Security says you are recovered. In this case you can keep your benefits until you complete the approved vocational rehabilitation program.

SSI/SSDI

18. WHAT IF I AM HOMELESS?

- The Social Security Office will make special arrangements to have a homeless person's check sent to a third party. The third party can be a relative, friend, or organization.
- If you are living in a public shelter you may receive a full SSI check for up to 6 months within any 9 month period. This rule is to enable you to save money for permanent housing.

SSI/SSDI

19. WHAT IF I GET A LETTER FROM SOCIAL SECURITY SAYING MY SSI OR SSDI WILL BE CHANGED?

YOU HAVE THE RIGHT TO APPEAL ANY DECISION THAT SOCIAL SECURITY MAKES EFFECTING YOUR BENEFITS!

- This includes denial of benefits, reduction of benefits, termination of benefits, charge of overpayment, or any other action effecting your benefits that you disagree with.

- You have 60 days from the time you receive the notice from Social Security to file your appeal

- **If you appeal within 10 days of receiving a notice from Social Security, your benefits will not be changed until the appeal is ruled upon**

- If you are charged with an overpayment you may be able to get a *Waiver* of the Overpayment ruling **(not have to pay it back)**

  This can be done if the overpayment was not your fault, and,

  if it would be a financial hardship for you to pay it back

  There is no time limit on filing a Waiver of Overpayment

  - If money is already being taken out of your check you can still file for a waiver of the overpayment

  - If the waiver is granted money will stop being taken out of your check, but you will not get back what has already been taken out

  The most that can be taken out of your check without your permission is 10% of the total check. If the check is $478.40, the most that can be taken out is $47.84

* * *

FREE SERVICES ARE AVAILABLE

IF YOU WOULD LIKE TO RECEIVE FREE HELP IN UNDERSTANDING AND USING THE SOCIAL SECURITY WORK INCENTIVES MENTIONED IN THIS BOOKLET, IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS WITH YOUR SSI OR SSDI BENEFITS, OR IF YOU THINK YOU ARE ELIGIBLE AND WOULD LIKE HELP IN APPLYING FOR THESE BENEFITS, CALL:

The MATRIX ADVOCACY PROJECT

at

MATRIX RESEARCH INSTITUTE
6008 Wayne Avenue
Philadelphia, PA 19144

(215) 438-8200

NOTES

GLOSSARY

APPEALS - The process of requesting that Social Security reconsiders a decision they have made, which will effect your benefits. You will have to provide information explaining why they should re-think their original decision. (page 19)

BREAKEVEN POINT - This is the amount of monthly income you can make on SSI when you will no longer be eligible to receive your SSI check. (page 7-8)

CLAIMS REPRESENTATIVE - The individual at the local Social Security office who has been assigned to handle your case.

COUNTABLE INCOME - The amount of your income, after appropriate deductions, which will reduce your check. (page 3-7)

DISABILITY REVIEW - A process where Social Security reviews your situation to determine if you continue to be eligible to receive benefits. This is done usually every 3-4 years. (page 18)

EARNED INCOME - Money received from working. This can be at a job, in self-employment, or from working in an agency sponsored workshop. (page 4-5)

EARNED INCOME DEDUCTION - The first $65 that you can receive in a month from earned income which will not reduce your SSI check at all. (page 4-5)

EXTENDED PERIOD OF ELIGIBILITY - The thirty-six month period following the completion of the 9-month Trial Work Period for people on SSDI. (page 15-16)

EXTENDED MEDICARE - Three additional months of Medicare that you are 0given after no longer being eligible for SSDI. (page 18)

GENERAL DEDUCTION - The first $20 that you can receive in unearned income in a month which will not reduce your SSI check. If there is no unearned income this can be applied to earned income in addition to the Earned Income Deduction. (page 3-5)

GROSS INCOME - Income amount before any deductions for taxes, insurance, social security, and other such deductions are made

IRWE - Impairment Related Work Expenses (page 12-13, 16-17)

OVERPAYMENT - Receiving benefits for months when you are not eligible due to unreported income or resources. This is money that will have to be paid back to Social Security.

PASS (SSI) - Plan for Achieving Self Support (page 10-12)

REINSTATEMENT - When you are placed back on benefits without having to reapply for them. (page 9-10)

1619(a) - A category of SSI when you begin to have gross earnings over $500 Social Security will schedule you for a Disability Review within twelve months. (page 18)

1619(b) - Program for extended Medicaid benefits for SSI recipients. (page 9)

SECTION 301 - This allows you to continue to receive benefits while you are in an approved vocational rehabilitation program until you complete that program, even after you have been determined to be no longer disabled. (page 19)

SUBSTANTIAL GAINFUL ACTIVITY (SGA) - An income amount between $300 and $500, over which SSDI beneficiaries do not receive a check when you are in the Extended Period of Eligibility. The figure most often used for SGA is $500. (page 15-16)

THRESHOLD AMOUNT (SSI) - The amount of income over which you are no longer eligible for 1619(b) extended Medicaid benefits. (page 9)

TRIAL WORK PERIOD - For SSDI beneficiaries only , any month where you earn over $200 is considered a trial work month. You have available to you nine trial work months in a rolling five year period. (page 14-15)

UNEARNED INCOME (SSI) - Income received without having worked for it, from such sources as Veterans Benefits, Retirement, or other such sources. (page 3-4)

WAIVER OF OVERPAYMENT - Appeal process for the reconsideration of a charge of overpayment. (page 20)

SSA

11.11 *Anterior poliomyelitis.*

With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis.*

With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy with disorganization of motor function as described in 11.04B.*

11.14 *Peripheral neuropathies.*

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis.*

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as described in 11.04B or 11.15B, no significantly improved by prescribed treatment.*

11.17 *Degenerative disease not listed elsewhere such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration.*

With:

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma:*

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia.*

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 MENTAL DISORDERS

The mental disorders listings in 12.00 of the Listing of Impairments will only be effective for 3 years unless extended by the Secretary or revised and promulgated again. Consequently, these listings will no longer b fective on August 28, 1988.

A. Introduction:

The evaluation of disability on the basis of me disorders requires the documentation of a medically terminable impairment(s) as well as consideration of degree of limitation such impairment(s) may impos the individual's ability to work and whether these li tions have lasted or are expected to last for a contin period of at least 12 months. The listings for me disorders are arranged in eight diagnostic categor organic mental disorders (12.02); schizophrenic, p noid and other psychotic disorders (12.03); effective orders (12.04); mental retardation and autism (12.0 anxiety related disorders (12.06); somatoform disord (12.07); personality disorders (12.08); and substance diction disorders (12.09). Each diagnostic group, exc listings 12.05 and 12.09, consists of a set of clin findings (paragraph A criteria), one or more of wh must be met, and which, if met, lead to a test of fu tional restrictions (paragraph B criteria), two or three which must also be met. There are additional consid ations (paragraph C criteria) in listings 12.03 and 12.0 discussed therein.

The purpose of including the criteria in paragrap of the listings for mental disorders is to medically s stantiate the presence of a mental disorder. Specific sig and symptoms under any of the listings 12.02 throu 12.09 cannot be considered in isolation from the descri tion of the mental disorder contained at the beginning o each listing category. Impairments should be analyzed o reviewed under the mental category(ies) which is sup ported by the individual's clinical findings.

The purpose of including the criteria in paragraphs and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorders are so constructed that an individual meeting or equaling the criteria could not reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equaled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder. (While RFC may be applicable in most claims, the law specifies that it does not apply to the following special claims categories: disabled title XVI children below age 18, widows, widowers and surviving divorced wives. The impairment(s) of these categories must meet or equal a listed impairment for the individual to be eligible for benefits based on disability.)

B. Need for Medical Evidence:

The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflected specific, abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. Assessment of Severity:

For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where "marked" is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* including adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

"Marked" is not the number of activities which are restricted but the overall degree of restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, e.g., supervisors, or cooperative behaviors involving coworkers.

"Marked" is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelli-

gence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. Documentation:

The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistence and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others, including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time many seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Roschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligences test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter international scale, or the Arthur adaption of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 69 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. *Chronic Mental Impairments:*

Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination may not adequately describe these individual's sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. *Effects of Structured Settings:*

Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital board and care facility or other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added to Listings 12.03 and 12.06.)

G. *Effects of Medication:*

Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairments severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted effect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. *Effect of Treatment:*

It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

I. *Techniques for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity:*

A special technique has been developed to ensure that all evidence needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in § 404.1520a and § 416.920a.

12.01 Category of Impairments-Mental

12.02 Organic Mental Disorders:

Psychological or behavorial abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment

index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 Schizophrenic, Paranoid and Other Psychotic Disorders:

Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior; or
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
   a. Blunt affect; or
   b. Flat affect; or
   c. Inappropriate affect;

OR

4. Emotional withdrawal and/or isolation:

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors); or
2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 Affective Disorders:

Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:
   a. Anhedonia or pervasive loss of interest in almost all activites; or
   b. Appetite disturbance with change in weight; or
   c. Sleep disturbance; or
   d. Psychomotor agitation or retardation; or
   e. Decreased energy; or
   f. Feelings of guilt or worthlessness; or
   g. Difficulty concentrating or thinking; or
   h. Thoughts of suicide; or
   i. Hallucinations, delusions or paranoid thinking; or
2. Manic syndrome characterized by at least three of the following;
   a. Hyperactivity; or
   b. Pressure of speech; or
   c. Flight of ideas; or
   d. Inflated self-esteem; or
   e. Decreased need for sleep; or
   f. Easy distractability; or
   g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
   h. Hallucinations, delusions or paranoid thinking;

OR

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience

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exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 Mental Retardation and Autism:

Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive or in the case of autism, gross deficits of social and communicative skills with two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-life settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 Anxiety Related Disorders:

In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

a. Motor tension; or
b. Autonomic hyperactivity; or
c. Apprehensive expectation; or
d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-liked settings which cause the individual to withdraw from the situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 Somatoform Disorders:

Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

a. Vision; or
b. Speech; or
c. Hearing; or
d. Use of a limb; or
e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or
f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sen-

sations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following.

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 Personality Disorders:

A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 Substance Addiction Disorders:

Behavioral change or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

A. Organic mental disorders. Evaluate under 12.02.

B. Depressive syndrome. Evaluate under 12.04

C. Anxiety disorders. Evaluate under 12.06.

D. Personality disorders. Evaluate under 12.08.

E. Peripheral neuropathies. Evaluate under 11.14.

F. Liver damage. Evaluate under 5.05.

G. Gastritis. Evaluate under 5.04.

H. Pancreatitis. Evaluate under 5.08.

I. Seizures. Evaluate under 11.02 or 11.03.

13.00 NEOPLASTIC DISEASES, MALIGNANT.

A. Introduction:

The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. Documentation:

The diagnosis of malignant tumors should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. Evaluation:

Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, "distant metastases" or "metastases beyond the regional lymph nodes" refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as "inoperable."

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not

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U.S. Department of
Health and Human Services
Social Security Administration
SSA Publication No. 05-10024
January 1994
ICN 454930

Understanding Social Security

10/94

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Who Should Read This Booklet?

You should!

Whether you're young or old, male or female, single or with a family—this booklet is for you and about you. That's because Social Security has programs that affect everybody.

Chances are you're either paying Social Security taxes or getting Social Security benefits—or you're related to somebody who is.

Whatever your situation, this booklet has information you will find helpful and useful.

It was prepared by the Social Security Administration and tells you what you need to know about Social Security while you're still working and what you need to know when it's your turn to collect benefits. It also provides an overview of Medicare and Supplemental Security Income (SSI) benefits.

Other booklets are available that explain all of the Social Security programs in more detail. And we have prepared a series of leaflets and factsheets that provide information about some of the finer points of Social Security. Page 33 lists some of these brochures.

> ***Please Note:*** This booklet provides a general overview of the Social Security program. The information it contains is not intended to cover all provisions of the law. For specific information about your case, contact a Social Security office.

We'd Like Your Comments

We'd like to know what you think about this booklet. Is there something you don't understand? Are there other topics you need to know about? Send your comments to:

Understanding Social Security Editor
Social Security Administration
P.O. Box 17743

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Social Security's
Toll-Free Number
1-800-772-1213

Part 1—Social Security's Future ... And Yours!

Is Social Security In Your Future?

Before we get started explaining the program, we think it's important to answer the first question many people have about Social Security. Perhaps you've asked it yourself. That question is: "Will Social Security be there when I need it?"

The simple and logical answer is, "Yes it will." But that answer deserves an explanation.

If you're concerned about the future of Social Security, it's probably because you've heard misleading stories about Social Security money being used for other purposes (which are partially true) and reports that the system's trust funds contain only "worthless IOU's" (which are false). Here are the facts. Out of every dollar you pay in Social Security taxes:

- 73 cents goes to a trust fund that pays monthly benefits to about 29 million retirees and their families and to about 8 million widows, widowers, and children of workers who have died;
- 19 cents goes to a trust fund that pays for the health care of 34 million Medicare beneficiaries; and
- 8 cents goes to a trust fund that pays benefits to about 5 million people with disabilities and their families.

Money not needed to pay these benefits is invested in U.S. government bonds-generally considered the safest of all investments. And the government uses the money it has *borrowed* from Social Security, just as it uses the money that you may have invested in treasury bonds, to pay for all the services and projects it provides for our citizens. But, just as the government pays you back with interest when you redeem your bonds, it has always made good on its obligations to Social Security. There's no reason to believe it won't continue to do so. If you own treasury bonds, it's a safe bet you don't consider them to be "worthless IOU's." We don't either. Our investments will be honored and we , in turn, will honor your investment in Social Security. It will be there when you need it!

When Will You Need Social Security?

Now that we've answered your first question and told you that Social Security will be there when you need it, the next question you may ask yourself is this: "When will I need it?"

If you're like most people, you tend to think of Social Security as a retirement program. Although it's true that most of our beneficiaries (about 60 percent) receive retirement benefits, many others get Social Security because:

- they are disabled;
- they are a dependent of someone who gets Social Security; or
- they are a widow, widower, or child of someone who has died.

So, depending on your circumstances, you may be eligible for Social Security at any age. In fact, Social Security pays more benefits to children than any other government program. Today, 45 million people, almost one out of every six Americans, collect some kind of Social Security benefit.

How To Reach Us When You Need Us

The Social Security Administration has about 1,300 offices in cities and towns across America. Of course, you're always welcome to visit the office nearest you.

But the easiest way to reach us is to call our toll-free number: **1-800-772-1213.** You can get information 24 hours a day. You can speak to a service representative between 7 a.m. and 7 p.m. on business days.

If you have a push-button (tone) phone, recorded information and services are available after 7 p.m. weekdays and all day on weekends and holidays.

If you want to speak to a representative, the best times to call are early in the morning and early in the evening. And if you can, it's best to call later in the week and later in the month. When you call, have your Social Security number handy.

Hearing-impaired callers using "TDD" equipment can reach Social Security between 7 a.m. and 7 p.m. on business days by calling **1-800-325-0778.**

The Social Security Administration treats all calls confidentially—whether they're made to our toll-free numbers or to one of our local offices. We also want to ensure that you receive accurate and courteous service. That's why we have a second Social Security representative monitor some incoming and outgoing telephone calls.

Your Future ... And This Booklet

Here's one final message about Social Security's future, your future, and this booklet: Social Security will be there—**whenever** you may need it.

But even though Social Security will be ready for you, will you be ready for Social Security?

This booklet will help you with the kinds of plans and decisions you need to make now in order to ensure a brighter and more secure financial future for you and your family.

Part 2—What You Need To Know About Social Security While You're Still Working

How Social Security Works—The General Idea

The basic idea behind Social Security is a simple one. You pay taxes into the system during your working years, and you and members of your family receive monthly benefits when you retire or become disabled. Or, your survivors collect benefits when you die.

> ***Here's An Important Point:*** Social Security is not intended to be your only source of income. Instead, it is meant to be used to supplement the pensions, insurance, savings, and other investments you will accumulate during your working years.

Your Social Security Number

What's your Social Security number? You probably know it as well as you know your own phone number.

We use your Social Security number to track your earnings while you're working and to track your benefits once you're getting Social Security.

Almost everybody reading this booklet already has a Social Security number. Today, even most young children have a number because the Internal Revenue Service requires that a Social Security number be shown on tax returns for all dependents age one and older.

In fact, most parents apply for a Social Security number for their newborn child when they provide information for the child's birth certificate. That's because most states make applying for a Social Security number part of the birth registration process. This is taken care of before the mother and child leave the hospital.

In addition to its "official" uses, banks, insurance companies, and many other businesses and government agencies use the Social Security number for recordkeeping purposes. Although we can't prevent others from asking for your number, you should know that if you give it to them they can **not** use it to get your Social Security records. We will not give out your records, without your written consent, unless the law requires or permits it.

The Social Security Administration is aware of concerns about the increasing uses of the Social Security number for identification and recordkeeping purposes. That concern centers on the issue of your right to privacy and the increasing possibility that it could be invaded if all your records are kept under one number. If a business or other enterprise asks for your Social Security number, you can refuse to give it to them. However, that may mean doing without the purchase or service for which your number was requested. Our primary message is this: be careful with your Social Security number and protect its privacy whenever possible.

If you need a Social Security number, if you lost your card and need another one, or if you need to change your name on your current card, just call or visit a Social Security office. We'll ask you to fill out a simple one-page application form. And we'll ask to see certain documents depending on your situation. (We need to see originals or certified copies.)

Some typical examples are:

- A birth certificate and some form of identification for a new card;
- Some form of identification for a replacement card;
- A marriage certificate or divorce papers for a name change.

The Taxes You Pay

Social Security taxes are used to pay for all Social Security benefits. In addition, a portion of your taxes is used to pay for part of your Medicare coverage. General tax revenues, not Social Security taxes, are used to finance the Supplemental Security Income (SSI) program.

If You Work For Someone Else

You and your employer pay taxes for Social Security and Medicare. In 1994, you and your employer each pay 7.65 percent of your gross salary, up to $60,600. The deduction might be labelled "FICA" on your pay slip. That stands for Federal Insurance Contributions Act, the law that authorized Social Security's payroll tax.

If You Work For Yourself

If you're self-employed, you pay 15.3 percent of your taxable income into Social Security, up to $60,600. However, there are special deductions you can take when you file your tax return that are intended to offset your tax rate.

> ***For More Information:*** If you would like to learn more about self-employment tax rates, call or visit Social Security to ask for a free copy of the factsheet, *If You're Self-Employed* (Publication No. 05-10022).

Extra Taxes For Medicare

If you make more than $60,600 in 1994, you continue to pay the Medicare portion of the Social Security tax on the rest of your earnings. The Medicare portion of the tax is 1.45 percent for employers and employees each, and 2.9 percent for self-employed people.

You Become Eligible For Social Security By Earning "Credits"

You must work and pay taxes into Social Security in order to get something out of it. (Of course, some people get benefits as a dependent or survivor on another person's Social Security record.)

As you work and pay taxes, you earn Social Security "credits." In 1994 you earn one credit for each $620 in earnings you have—up to a maximum of four credits per year. (The amount of money needed to earn one credit goes up every year.)

Most people need 40 credits (10 years of work) to qualify for benefits. Younger people need fewer credits to be eligible for disability benefits or for their family members to be eligible for survivors benefits if they should die.

During your working lifetime, you probably will earn many more credits than you need to be eligible for Social Security. The fact that you earn these extra credits does not increase your eventual Social Security benefit. However, the income you earn while working will increase your benefit, as you will learn in the next two sections.

> ***For More Information:*** If you want to learn more about the number of credits you would need to qualify for benefits, just call or visit Social Security to ask for a *Personal Earnings and Benefit Estimate Statement* (see the next section), or ask for a free copy of one of the following booklets: *Retirement*, (Publication No. 05-10035), *Survivors* (Publication No. 05-10084), or *Disability* (Publication No. 05-10029).

How Much Will You Get From Social Security?

The amount of your Social Security benefit is based on factors such as your date of birth, the type of benefit you are applying for, and most important, your earnings.

This booklet will explain in a general way how a Social Security benefit is figured. In the back of this booklet, you will find tables that give examples of Social Security benefits. But if you would like a detailed, personal estimate of your Social Security retirement, disability, and survivors benefits, all you have to do is call or visit Social Security and ask for it. We will send you a form you can use to get a *Personal Earnings and Benefit Estimate Statement.*

How Your Benefit Is Figured

In general, a Social Security benefit is based on your earnings averaged over your working lifetime. This is different from many private pension plans that are usually based on a relatively small number of years of earnings.

In its simplest terms, here's how your Social Security benefit is figured:

Step 1—We determine the number of years of earnings to use as a base.

Retirement benefits: For everybody born after 1928 and retiring in 1991 or later, which includes most people reading this booklet, that number is 35 years. Fewer years are used for people born in 1928 or earlier.

Disability and survivors benefits: We use most of the years of earnings posted to your record.

Step 2—We adjust these earnings for inflation.

Step 3—We determine your **average** adjusted monthly earnings based on the number of years figured in step 1.

Step 4—We multiply your average adjusted earnings by percentages in a formula that is specified by law.

That formula results in benefits that replace about 42 percent of a person's earnings. This applies to people who had **average** earnings during their working years. The percentage is lower for people in the upper income brackets and higher for people with low incomes. (That's because the Social Security benefit formula is weighted in favor of low-income workers who have less opportunity to save and invest during their working years.)

If You Didn't Earn Enough Credits To Get Social Security

If you haven't worked long enough to get Social Security, or if you get only a small amount, you may be eligible for Supplemental Security Income, or SSI. For more information, see page 22.

Part 3—What You Need To Know When You Become Eligible For Social Security

How And When To Sign Up For Social Security

You can apply for benefits at any Social Security office. The easiest way to file a claim is to call our toll-free number ahead of time for an appointment. That number is: **1-800-772-1213.**

For disability, survivors, and SSI benefits, you should apply as soon as you're eligible. (The rest of this chapter will help you decide if and when you are.) When signing up for retirement, we ask that you talk to a Social Security representative in the year before the year you plan to retire. That's because the rules are complicated, and it may be to your advantage to start your retirement benefits before you actually stop working.

What Records Will You Need?

To show that you are eligible for Social Security and to help us decide how much your benefits should be, there are certain documents we may ask you to provide. The ones you'll need depend on the circumstances of your claim. Here is a list of some of the documents you may need when you sign up for Social Security:

- Your Social Security card (or a record of your number);
- Your birth certificate;
- Children's birth certificates (if they are applying);
- Marriage certificate (if signing up on a spouse's record);
- Your most recent W-2 form, or your tax return if you're self-employed.

This is just a partial list to help you get prepared. When you actually sign up for Social Security, we'll let you know if other documents are needed.

> ***Here's An Important Point***: If you don't have all the documents you need, don't delay signing up for Social Security. We'll help you get the information you need.

Direct Deposit

You have a choice of how you receive your Social Security or SSI payments. Your benefit can either be deposited directly into your bank account or come to you in the mail. Most people have their benefits deposited in their bank account because it is safer and more convenient than receiving checks. It is also more efficient and saves money for the government.

If you choose direct deposit, have your checkbook or any papers that show your bank account number with you when you sign up for Social Security.

Retirement Benefits

This section of the booklet provides a brief overview of Social Security retirement benefits. If you want to learn more about the program, call or visit Social Security to ask for a free copy of the booklet, *Retirement* (Publication No. 05-10035).

Full Retirement

If you were born before 1938, you will be eligible for your full Social Security benefit at the age of 65.

However, beginning in the year 2000, the age at which full benefits are payable will increase in gradual steps from 65 to 67. This affects people born in 1938 and later. For example, if you were born in 1940, your full retirement age is 65 and 6 months. If you were born in 1950, your full retirement age is 66. Anybody born in 1960 or later will be eligible for full retirement benefits at 67.

Reduced Benefits As Early As 62

No matter what your "full" retirement age is, you may start receiving benefits as early as 62. However, if you start your benefits early, they are reduced five-ninths of one percent for each month before your "full" retirement age. For example, if your full retirement age is 65 and you sign up for Social Security when you're 64, you will receive 93 ⅓ percent of your full benefit. At 62, you would get 80 percent. (Note: The reduction will be greater in future years as the full retirement age increases.)

Here's An Important Point: There are disadvantages and advantages to taking your benefit before your full retirement age. The disadvantage is that your benefit is permanently reduced. The advantage is that you collect benefits for a longer period of time. Each person's situation is different, so make sure you check with Social Security before you decide to retire.

What About Late Retirement?

Some people continue to work full time beyond their full retirement age—and they do not sign up for Social Security until later. This delay in retirement can increase your Social Security benefit in two ways:

- Your extra income usually will increase your "average" earnings, and the higher your average earnings, the higher your Social Security benefit will be.
- In addition, a special credit is given to people who delay retirement. This credit, which is a percentage added to your Social Security benefit, varies depending on your date of birth. For people turning 65 in 1994, the rate is 4.5 percent per year. That rate gradually increases in future years, until it reaches 8 percent per year for people turning 65 in 2008 or later.

How Much Will You Get?

On Page 11, we explained how you can get a personalized estimate of the benefits you are due. In addition, there is a chart on Page 34 that gives examples of retirement benefit rates.

Disability Benefits

This section of the booklet provides a brief overview of Social Security's disability program. It concentrates primarily on benefits for people who have worked and earned enough Social Security "credits" to qualify for disability on their own work record.

However, it is important to note that other kinds of disability benefits are available from Social Security, depending on your circumstances. These include:

- Widows and widowers with disabilities who are eligible for benefits on the record of a spouse;
- People with disabilities who have low income and few assets who might be eligible for SSI benefits;
- Children over age 18 with disabilities who might be eligible for Social Security benefits on the record of a parent, or children of any age with disabilities who might be eligible for SSI benefits on their own.

For More Information: Because disability is one of the most complicated of all Social Security programs, we recommend that you call or visit Social Security to ask for a free copy of the booklet, *Disability* (Publication No. 05-10029), for more in-depth information.

For information about benefits available to children with disabilities, see page 24 of this booklet, or call or visit Social Security and ask for a free copy of the publication, *Social Security and SSI Benefits For Children With Disabilities* (Publication No. 05-10026).

What Do We Mean By "Disability"?

What is a "disability"? The dictionary defines it as "a physical or mental condition that prevents a person from leading a normal life." But Social Security's definition of disability is more specific and is generally related to your ability to work.

To qualify for disability from Social Security, you must have a physical or mental impairment that is expected to keep you from doing any "substantial" work for at least a year. Generally, monthly earnings of $500 or more are considered substantial. Or you must have a condition that is expected to result in your death.

This is a strict definition of disability. Unlike many private pension plans or even other government disability programs, Social Security is not intended for a temporary condition. In other words, there is no such thing as a "parti[illegible]isability payment from Social Security.

What You Should Do If You Become Disabled

If you become disabled, you should file for disability benefits as soon as possible. You can do this by calling or visiting any Social Security office.

You can shorten the time it takes to process your claim if you have the following medical and vocational information when you apply:

- The names, addresses, and phone numbers of your doctors, and of hospitals, clinics, etc., where you have been treated; and
- A summary of where you worked in the last 15 years and the kind of work you did.

Here's An Important Point: Social Security's disability rules are different from those of other private plans or government agencies. So the fact that you qualify for disability from somebody else does not mean you will be eligible for Social Security. Further, the fact that you have a statement from your doctor indicating you are disabled does not mean you will be automatically eligible for Social Security disability payments.

When Do Your Disability Benefits Start?

If we decide you are disabled, in most cases your monthly benefits will begin with the sixth full month of your disability. Here's a simple example of how this works:

> John has a severe heart attack on March 15. He files for disability on March 29, and his claim is approved on May 30. September is the sixth full month that he is disabled, so his benefits begin that month. Social Security checks are usually paid on the third of the following month, so John's first check (the September check) will arrive October 3.

Here's An Important Point: Do not delay signing up for Social Security because of this "waiting period." By filing early, all the paperwork will be processed before your first check is due. There is no waiting period for disabled children's benefits or for SSI disability payments.

How Much Will You Get?

On Page 11, we told you how you can get a personalized estimate of any benefits you are due. There is a chart on Page 35 that gives examples of disability benefit rates.

Workers' Compensation

If you get workers' compensation or certain other government disability benefits, your Social Security disability benefit may be reduced. Or, your Social Security benefits may reduce your other disability payments. The sum of all disability payments to you and your family cannot exceed 80 percent of your earnings averaged over a period of time shortly before you became disabled.

How Long Will Your Disability Benefits Continue?

You will continue to get disability benefits unless your condition improves or you return to "substantial" work (see Page 16). We check your claim periodically to determine if this is the case. To help us decide, you may be asked to undergo a special test or examination that we will pay for.

Incentives To Return To Work

There are special rules that help people who would like to return to work but are concerned about the effect this might have on their disability benefits. These rules offer special incentives that permit people to try working without the risk of a sudden loss of their monthly benefits and their Medicare coverage.

> ***For More Information:*** If you would like to learn more about these special work incentives, call or visit Social Security to ask for a free copy of the booklet, *Working While Disabled ... How Social Security Can Help* (Publication No. 05-10095).

Benefits For Your Family

This section of the booklet provides a brief overview of benefits payable to members of your family when you are eligible for retirement or disability benefits.

Who Can Get Benefits?

When you start collecting Social Security retirement or disability benefits, other members of your family might also be eligible for payments. For example, benefits can be paid to:

- Your husband or wife if he or she is 62 or older (unless he or she collects a higher Social Security benefit on his or her own record);
- Your husband or wife at any age if he or she is caring for your child (the child must be under 16 or disabled and receiving Social Security benefits);
- Your children, if they are unmarried and:
  - — Under 18; or
  - — Under 19 but in elementary or secondary school as a full-time student; or
  - — 18 or older and severely disabled (the disability must have started before age 22).

How Much Can Family Members Get?

Usually, each family member will be eligible for a monthly benefit that is up to 50 percent of your retirement or disability rate. However, there is a limit to the amount of money that can be paid to a family on your Social Security record. The limit varies, but is generally equal to about 150 to 180 percent of your retirement benefit. (It may be less for disability benefits.) If the sum of the benefits payable on your account is greater than this family limit, then the benefits to the family members will be reduced proportionately. Your benefit will not be affected.

Benefits For Divorced People

If you are divorced (even if you have remarried), your ex-spouse can be eligible for benefits on your record. In some situations, he or she could get benefits even if you're not receiving them. In order to qualify, your ex-spouse must:

- Have been married to you for at least 10 years;
- Be at least 62 years old;
- Be unmarried;
- Not be eligible for an equal or higher benefit on his or her own Social Security record, or on someone else's Social Security record.

  Here's An Important Point: If your ex-spouse receives benefits on your account, it does not affect the amount of any benefits payable to you or your other family members.

Survivors Benefits

This section of the booklet provides a brief overview of the benefits payable when a family breadwinner dies. For more information, call or visit Social Security to ask for a free copy of the booklet, *Survivors* (Publication No. 05-10084).

Who Can Receive Survivors Benefits?

When you die, certain members of your family may be eligible for benefits on your Social Security record if you had earned enough credits while you were working.

The family members who can collect benefits include:

- A widow or widower who is 60 or older;
- A widow or widower who is 50 or older and disabled;
- A widow or widower at any age if she or he is caring for a child under 16 or a disabled child who is receiving Social Security benefits;

- Children if they are unmarried and:
  - — Under 18; or
  - — Under 19 but in an elementary or secondary school as a full-time student; or
  - — 18 or older and severely disabled (the disability must have started before age 22);
- Your parents, if they were dependent on you for at least half of their support.

Special One-Time Death Benefit

If you had enough credits, a special one-time payment of $255 also will be made after your death. This benefit is paid only to your widow(er) or minor children.

Benefits To Divorced Widows And Widowers

If you are divorced (even if you have remarried), your ex-spouse will be eligible for benefits on your record when you die. In order to qualify, your ex-spouse must:

- Be at least 60 years old (or 50 if disabled) and have been married to you for at least 10 years;
- Be any age if caring for a child who is eligible for benefits on your record;
- Not be eligible for an equal or higher benefit on his or her own record;
- Not be currently married, unless the remarriage occurred after 60—or 50 for disabled widows. (In cases of remarriage after the age of 60, your ex-spouse will be eligible for a widow's benefit on your record or a dependent's benefit on the record of his or her new spouse, whichever is higher.)

  Here's An Important Point: If your ex-spouse receives benefits on your account, it does not affect the amount of any benefits payable to other survivors on your record.

How Much Will Your Survivors Get?

The amount payable to your survivors is a percentage of your basic Social Security benefit—usually in a range from 75 percent to 100 percent each. However, there is a limit to the amount of money that can be paid each month to a family. The limit varies, but is generally equal to about 150 to 180 percent of your benefit rate. If the sum of the benefits payable to your surviving family members is greater than this limit, then the benefits to your family will be reduced proportionately.

The *Personal Earnings and Benefit Estimate Statement*, explained on Page 11, will provide you with a more accurate measurement of potential survivors benefits payable on your record. In addition, there is a chart on Page 36 that gives examples of survivors benefit rates.

Retirement Benefits For Widow(er)s

If you are receiving widows or widowers (including divorced widows or widowers) benefits, you should remember that you can switch to your own retirement benefits (assuming you're eligible and your retirement rate is higher than your widow's rate) as early as age 62. In many cases, a widow(er) can begin receiving one benefit at a reduced rate and then switch to the other benefit at an unreduced rate at age 65. The rules are complicated and vary depending on your situation, so you should talk to a Social Security representative about the options available to you.

Supplemental Security Income

This section of the booklet provides a brief overview of the Supplemental Security Income (SSI) program. For more information, call or visit Social Security to ask for a free copy of the booklet, *SSI* (Publication No. 05-11000).

What Is Supplemental Security Income?

Supplemental Security Income is usually called "SSI" for short. Although this program is run by Social Security, the money to pay for SSI benefits does not come from Social Security taxes or Social Security trust funds. SSI payments are financed by the general revenue funds of the U.S. Treasury.

SSI makes monthly payments to people who have low incomes and few assets. In addition, to get SSI you must:

- Be living in the U.S. or the Northern Mariana Islands;
- Be a U.S. citizen or be living in the U.S. legally;

And you must be:

- 65 or older; or
- Blind; or
- Disabled.

Here's An Important Point: Children as well as adults can get SSI benefits because of blindness or disability. See Page 24 for more information.

Income And Asset Limits For SSI

To get SSI, your income and the value of the things you own must be below certain limits.

By the term **income,** we mean the money you have coming in such as earnings, Social Security, or other government checks, pensions, etc. But we also mean "non-cash" items you receive such as the value of free food and shelter.

How much income you can have and still get SSI depends on whether you work or not—and in which state you live. Although there is a basic national SSI payment rate, some states add money to the national payment, so they have higher SSI rates and higher income limits than others. Check with your local Social Security office to find what the SSI rates and income limits are in your state.

Assets are the things you own such as property, cash, and bank accounts. But we don't count everything you own when we decide if you can get SSI. For example, we don't count your home and many of your personal belongings, and we usually don't count your car.

You may be able to get SSI if the things you own that we count are worth no more than:

- $2,000 for one person; or
- $3,000 for a couple.

Unlike the income category, these limits do not change from state to state.

How Much Can You Get From SSI?

How much you will get from SSI depends on your other income and where you live. The basic monthly SSI check is the same in all states—$446 for one person and $669 for a couple. But some states add money to the basic rate, so you may get more if you live in one of these states. You will get less if you have other income or if someone helps pay for your food and shelter.

For more information about SSI rates in your state, contact your local Social Security office.

SSI For People With Disabilities—Including Children

People with disabilities, including children, can get SSI if their income and assets are below the limits discussed in the previous sections.

Most of the rules used to decide if a person has a condition severe enough to qualify for Social Security disability benefits also apply to SSI.

And as with Social Security, the SSI program has special plans designed to help people who want to try going back to work without the risk of suddenly losing their benefits or Medicaid coverage. To learn more about these special plans, ask for a copy of the booklet, *Working While Disabled ... How Social Security Can Help* (Publication No. 05-10095).

Social Security has special guidelines for evaluating disability in children filing for SSI benefits. If you have a child with a disability, contact your local Social Security office to apply for SSI disability benefits.

For special information about benefits for children with disabilities, ask for a copy of the publication, *Social Security and SSI Benefits For Children With Disabilities* (Publication No. 05-10026).

Other Help You Can Get

Most people who get SSI can also get food stamps and "Medicaid" assistance. Medicaid, which is a different program than Medicare, helps pay doctor and hospital bills. For more information about food stamps, ask Social Security for a copy of the factsheet, *Food Stamp Facts* (Publication No. 05-10101). For more information about Medicaid, contact your local social services office.

Medicare

Medicare is our country's basic health insurance program for people 65 or older and many people with disabilities.

You should not confuse Medicare and Medicaid. Medicaid is a health insurance program for people with low income and limited assets. It is usually run by state welfare or social service agencies. Some people qualify for one or the other; some qualify for both Medicare and Medicaid.

This booklet provides only a brief overview of the Medicare program. If you would like to learn more about Medicare, call or visit Social Security to ask for a free copy of the booklet, *Medicare* (Publication No. 05-10043).

Medicare Has Two Parts

There are two parts to Medicare:

- Hospital insurance (sometimes called "Part A") — This helps pay for inpatient hospital care and certain followup services; and
- Medical insurance (sometimes called "Part B") — This helps pay for doctors' services, outpatient hospital care, and other medical services.

Who Is Eligible For Hospital Insurance (Part A)?

Most people get hospital insurance when they turn 65. You qualify for it automatically if you are eligible for Social Security or Railroad Retirement benefits. Or you may qualify on a spouse's (including divorced spouse's) record. Others qualify because they are government employees not covered by Social Security who paid the Medicare part of the Social Security tax.

In addition, if you have been getting Social Security disability benefits for 24 months, you will qualify for hospital insurance.

Also, people who have permanent kidney failure that requires maintenance dialysis or a kidney replacement qualify for hospital insurance if they are insured or if they are the spouse or child of an insured worker.

Almost everybody qualifies for hospital insurance through one of the above methods. But if you don't and if you're 65 or older, you can buy hospital insurance just like you can buy other health insurance policies.

Who Can Get Medical Insurance (Part B)?

Almost anyone who is eligible for hospital insurance can sign up for medical insurance. Unlike Part A, which was paid for by your taxes while you worked and is free when you're eligible for it, Part B is an optional program that generally costs $41.10 per month. Almost everybody signs up for this part of Medicare.

How Do You Get Medicare?

If you are already getting Social Security benefits when you turn 65, you will be automatically enrolled in Medicare (although you have the opportunity to turn down "Part B").

If you are disabled, you will be automatically enrolled in Medicare after you have been getting disability benefits for 24 months. (And you can turn down "Part B" if you want.)

If you turn 65 but plan to keep working and do not plan to sign up for Social Security at that time, you should call or visit a Social Security office so we can help you decide if you should sign up for Medicare only.

There are many other rules associated with Medicare enrollment **including penalties for not enrolling in Part B when you're first eligible.** Please contact your Social Security office for more details.

What Does Medicare Pay For?

Medicare hospital insurance helps pay for:

- Inpatient hospital care;
- Skilled nursing facility care;
- Home health care;
- Hospice care.

Medicare medical insurance helps pay for:

- Doctors' services;
- Outpatient hospital services;
- Home health visits;
- Diagnostic X-ray, laboratory, and other tests;
- Necessary ambulance services; and
- Other medical services and supplies.

What Medicare Does Not Pay For

Not all health services are covered by Medicare. For example, Medicare does **not** pay for:

- Custodial care;
- Dentures and routine dental care;
- Eyeglasses, hearing aids, and examinations to prescribe and fit them;
- Nursing home care (except skilled nursing care);
- Prescription drugs; and
- Routine physical checkups and related tests.

Help For Low-Income Medicare Beneficiaries

If you get Medicare and have low income and few resources, your state may pay your Medicare premiums and, in some cases, other "out-of-pocket" Medicare expenses such as deductibles and coinsurance. Only your state can decide if you qualify. To find out if you do, contact your state or local welfare office or Medicaid agency. For more general information about the program, contact Social Security and ask for a copy of the leaflet, *Medicare Savings For Qualified Beneficiaries* (HCFA Publication No. 02184).

Part 4—What You Need To Know After You Sign Up For Social Security

After you've signed up for retirement, disability, survivors, Medicare, or SSI benefits, your involvement with Social Security is just beginning. This section of the booklet provides a brief overview of a few things you need to know about your benefits and how they work.

When you start getting Social Security, we send you a booklet that explains your rights and responsibilities. In addition, we produce a variety of publications that explain other facts you need to know about Social Security and SSI. **If you need more information,** call or visit

Social Security to tell us your situation. There is probably a pamphlet or factsheet we can send you that will answer your questions.

What You Need To Report To Us

People who get Social Security should let us know when something happens that might affect their benefits. Here are some examples:

- If they move;
- If they get married or divorced;
- If their name changes;
- If their income or earnings change;
- If a child is born or adopted;
- If a beneficiary is imprisoned;
- If they leave the United States;
- If a beneficiary dies.

If You Disagree With A Decision We Make

Whenever we make a decision that affects your eligibility for Social Security or SSI benefits, we send you a letter that explains our decision. If you disagree with our decision, you have the right to appeal it. In other words, you can ask us to review your case. If our decision was wrong, we will change it.

> ***For More Information:*** To learn more about the appeals process, call or visit any Social Security office to ask for a copy of the factsheet called *The Appeals Process* (Publication No. 05-10041). In addition, you have the right to be represented by a qualified person of your choice when dealing with Social Security. For more information, ask us for a copy of the factsheet, *Social Security And Your Right To Representation* (Publication No. 05-10075).

How Your Earnings Affect Your Benefits

There is a provision in the law that limits the amount of money you can earn and still collect all your Social Security benefits. This provision affects people under the age of 70 who collect Social Security retirement, dependents, or survivors benefits. (Earnings in or after the month you reach age 70 won't affect your Social Security benefits.) **People who work and collect disability or SSI benefits have different earnings requirements and should report all their income to Social Security.**

If you are under age 65, you can earn up to $8,040 in 1994 and still collect all your Social Security benefits.

However, for every $2 you earn over $8,040, $1 will be withheld from your Social Security benefits.

If you are age 65 through 69, you can earn up to $11,160 in 1994 and still collect all your Social Security benefits.

However, for every $3 you earn over $11,160, $1 will be withheld from your Social Security benefits.

We count only the earnings you make from a job or your net profit if you're self-employed. This includes compensation such as bonuses, commissions, and vacation pay. It does not include such items as pensions, annuities, investment income, interest, Social Security, veterans, or other government benefits.

> *For More Information:* If you would like to learn more about the Social Security earnings limits and how they affect you, call or visit any Social Security office to ask for a free copy of How Work Affects Your Social Security Benefits (Publication No. 05-10069).

Your Benefits May Be Taxable

Some people who get Social Security will have to pay taxes on their benefits. You will be affected only if you have substantial income in addition to your Social Security benefits.

If you file a Federal tax return as an "individual," and your combined income* is between $25,000 and $34,000, you may have to pay taxes on 50 percent of your Social Security benefits. If your combined income* is above $34,000, 85 percent of your Social Security benefits is subject to income tax.

If you file a joint return, you may have to pay taxes on 50 percent of your benefits if you and your spouse have a combined income* that is between $32,000 and $44,000. If your combined income* is more than $44,000, 85 percent of your Social Security benefits is subject to income tax.

If you are a member of a couple and file a separate return, you probably will pay taxes on your benefits.

*"Combined income" means your and your spouse's adjusted gross income (as reported on your Form 1040) plus nontaxable interest plus one-half or your Social Security benefits.

For More Information: If you would like more information about the taxation of your Social Security benefits, there are some IRS publications that will help you. Call or visit IRS to ask for a copy of Publication 554, *Tax Information for Older Americans*, and Publication 915, *Social Security Benefits And Equivalent Railroad Retirement Benefits.*

When Somebody Needs Help Managing Benefits

Sometimes, people who receive Social Security or SSI are not able to handle their own financial affairs. In those cases, and after a careful investigation, we appoint a relative, a friend, or another interested party to handle their Social Security matters. We call that person a "representative payee." All Social Security or SSI benefits due are made payable in the representative payee's name on behalf of the beneficiary.

Here's An Important Point: If you have "power of attorney" for someone, that does not automatically qualify you to be his or her representative payee.

If you are a representative payee, you have important responsibilities.

- You must use the Social Security or SSI benefits for the personal care and well-being of the beneficiary. Any excess funds must be saved on the beneficiary's behalf.
- You must keep Social Security informed of any events that might affect the beneficiary's eligibility for benefits. For example, you should tell us if the beneficiary moves or gets a job. And, of course, you should tell us when the beneficiary dies.
- You must file a periodic accounting report with Social Security that shows how you spent or saved the benefits you were paid.

For More Information: If you would like to learn more about receiving benefits on behalf of another individual, call or visit any Social Security office to ask for a copy of the brochure, *A Guide For Representative Payees* (Publication No. 05-10076).

Other Booklets Available

We said right up front that this booklet was intended to provide a general overview of Social Security programs and how they might affect you. Throughout this booklet, we referred you to other publications whenever the situation required more information or a more detailed explanation.

The Social Security Administration and the Health Care Financing Administration (the Medicare people) produce many publications and factsheets designed to help explain these programs to you. Here is a list of some you may find helpful.

- *Retirement* (Publication No. 05-10035)—A guide to Social Security retirement benefits
- *Disability* (Publication No. 05-10029)—A guide to Social Security disability benefits
- *Survivors* (Publication No. 05-10084)—A guide to Social Security survivors benefits
- *Medicare* (Publication No. 05-10043)—A guide to the Medicare program
- *SSI* (Publication No. 05-11000)—A guide to the Supplemental Security Income program
- *Social Security And SSI Benefits For Children With Disabilities* (Publication No. 05-10026)—An overview of benefits available to children
- *A Guide To Social Security And SSI Disability Benefits For People With HIV Infection* (Publication No. 05-10020)—An explanation of benefits for people with the AIDS virus
- *Financing Social Security* (Publication No. 05-10094)—A factsheet that provides an overview of Social Security's trust fund operations

These and other publications can be obtained free of charge at any Social Security office or by calling our toll-free number: **1-800-772-1213.**

Examples of Benefits

Approximate Monthly Benefits If You Retire At Full Retirement Age And Had Steady Lifetime Earnings

		Your Earnings in 1993				
Your Age In 1994	Your Family	$20,000	$30,000	$40,000	$50,000	$57,600 Or More[1]
45	You	$ 777	$1,044	$1,177	$1,301	$1,400
	You and your spouse[2]	1,165	1,566	1,765	1,953	2,100
55	You	777	1,043	1,157	1,244	1,302
	You and your spouse[2]	1,165	1,564	1,735	1,866	1,953
65	You	752	998	1,076	1,127	1,147
	You and your spouse[2]	1,128	1,497	1,616	1,690	1,720

[1] Use this column if you earn more than the maximum Social Security earnings base.

[2] Your spouse is assumed to be the same age as you. Your spouse may qualify for a higher retirement benefit based on his or her own work record.

Note: The accuracy of these estimates depends on the pattern of your actual past earnings and on your earnings in the future. Your actual benefit probably will be higher because these estimates are shown in today's dollars.

Approximate Monthly Benefits If You Become Disabled In 1994 And Had Steady Earnings

		Your Earnings In 1993				
Your Age	Your Family	$20,000	$30,000	$40,000	$50,000	$57,600 Or More[1]
25	You	$ 777	$ 1,044	$1,177	$1,302	$1,382
	You, your spouse, and child[2]	1,166	1,567	1,765	1,953	2,073
35	You	777	1,044	1,177	1,302	1,364
	You, your spouse, and child[2]	1,166	1,567	1,765	1,953	2,047
45	You	777	1,044	1,172	1,266	1,303
	You, your spouse, and child[2]	1,166	1,567	1,759	1,899	1,954
55	You	777	1,039	1,137	1,201	1,226
	You, your spouse, and child[2]	1,166	1,558	1,706	1,801	1,839
64	You	756	1,000	1,082	1,132	1,152
	You, your spouse, and child[2]	1,135	1,501	1,624	1,699	1,729

[illegible]se this column if you earn more than the maximum Social Security earnings base.

[2] Equals the maximum family benefit.

Note: The accuracy of these estimates depends on the pattern of your actual past earnings. Your actual benefit probably will be higher because these estimates are shown in today's dollars.

Approximate Monthly Survivors Benefits If The Worker Dies In 1994 And Had Steady Earnings

Worker's Age	Your Family	Deceased Worker's Earnings In 1993				
		$20,000	$30,000	$40,000	$50,000	$57,600 Or More[1]
35	Spouse and 1 child[2]	$1,166	$1,566	$1,764	$1,952	$2,056
	Spouse and 2 children[3]	1,458	1,829	2,061	2,279	2,400
	1 child only	583	783	882	976	1,028
	Spouse at age 60[4]	556	746	841	931	980
45	Spouse and 1 child[2]	1,166	1,566	1,760	1,908	1,968
	Spouse and 2 children[3]	1,458	1,829	2,055	2,228	2,296
	1 child only	583	783	880	954	984
	Spouse at age 60[4]	556	746	839	910	938
55	Spouse and 1 child[2]	1,166	1,558	1,706	1,800	1,838
	Spouse and 2 children[3]	1,458	1,819	1,991	2,102	2,146
	1 child only	583	779	853	900	919
	Spouse at age 60[4]	556	743	813	858	876

[1] Use this column if the worker earned more than the maximum Social Security earnings base.

[2] Amounts shown also equal the benefits paid to two children, if no parent survives or surviving parent has substantial earnings.

[3] Equals the maximum family benefit.

[4] Amounts payable in 1994. Spouses turning 60 in the future would receive higher benefits.

Note: The accuracy of these estimates depends on the pattern of your actual past earnings. Your actual benefit probably will be higher because these estimates are shown in today's dollars.

Fingertip Facts

Here's a summary of important Social Security information

1994 Social Security and Medicare Taxes

- You and your employer each pay 7.65 percent up to $60,600
- If you're self-employed, you pay 15.3 percent up to $60,600

Extra Taxes For Medicare In 1994

- You and your employer each pay 1.45 percent on all wages above $60,600
- If you're self-employed, you pay 2.9 percent on all net earnings above $60,600

Work Credits In 1994

- For each $620 you earn, you receive one Social Security "credit" up to four per year
- Most people need 40 credits to be eligible for retirement benefits
- Younger people need fewer credits to qualify for disability and survivors benefits

Average 1994 Social Security Benefits

- retired individual: $674
- retired couple: $1,140
- disabled individual: $641
- disabled individual with a spouse and child: $1,092
- widow(er): $631
- young widow(er) with 2 children: $1,316

1994 Earnings Limits

- If you're under 65, you can earn up to $8,040 with no reduction in benefits; for every $2 you earn over $8,040, $1 is withheld from benefits
- If you're 65-69, you can earn up to $11,160 with no reduction in benefits; for every $3 you earn over $11,160, $1 is withheld from benefits
- If you're 70 or older, there is no limit on your earnings

1994 SSI Payment Rates
(does not include state supplement, if any)

- $446 for an individual
- $669 for a couple

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CASE STUDY

G

(see Videotape)

2 min., 36 sec.
(see Videotape)

THE REALITIES OF FINANCIAL DISINCENTIVES

While job placement is typically viewed as the end result of most psychiatric-vocational rehabilitation efforts by the counselor, for the client it is only the beginning. The following videotape illustrates the realities of both the incentives and disincentives to employment faced by persons having a psychiatric disability. Consumer concerns are discussed in terms of two broad categories of change and adjustment necessitated by employment. The first covers the more specific and tangible financial picture as changes occur across the entire spectrum of consumer benefits as a result of earned income. Consumers must cope with reductions of varying amounts in SSI, SSDI or public assistance checks, the loss of food stamps, energy, child care, and transportation assistance, and often significant increases in housing and utility costs. Budgeting, banking, and financial planning may become formidable tasks especially for those who have had limited experience in these areas. Confusion around changes in medical insurance and fears about complete loss of coverage are frequently paramount.

The second major area of change and adjustment facing the newly employed consumer lies in quality of life issues, such as management of one's time, social and recreational activities, and affairs of everyday living. Adjusting one's sleep schedule, laundry and shopping days, social activities, and medical appointment times around fluctuating work schedules requires improved time management skills and can be highly stressful.

It is recommended that counselors maintain an intimate working knowledge of the various benefit programs in which their clients participate and be willing to intervene directly in them and advocate on behalf of their clients. Education, support, and direct skills teaching in areas such as budgeting and time and money management may be necessary over a sustained period of time if consumers are to successfully maintain their newfound employment and achieve a truly more independent and autonomous status.

CASE STUDY

Background Information

The patient dates her first psychotic episode in 1970 when she was living with her grandfather. At that time, she says she had auditory hallucinations receiving special messages from pictures on the wall, as well as from the television set. The voices were saying to her that she was sick. Additionally she reports religious ideation and states that St. Peter and God were talking to her telling her to "be religious." She describes delusions that she felt she was "Diane Ross." Additionally she reports social isolation and decreased concentration, depersonalization. At times she has felt that her surroundings were unreal to her. She said that at times her thoughts were "mixed up" and she recalls that her friends and family could not understand what she was trying to say. The patient reports that at the time of her first psychiatric episode, her mother and four half siblings had moved to Washington, D.C. She states that she did not want to go to Washington, D.C. and elected to stay with her grandfather.

Following the patient's first psychotic episode, she was hospitalized at Woodville for two months and then followed at Western Psychiatric Institute and Clinic (WPIC) as an outpatient. She was taking Thorazine, Stelazine, and Vivactil at that time. However, she failed to keep her appointments at WPIC. Patient's schizophrenia was in remission from 1970 until 1975. During this period of time, patient received her beautician's license in 1971 and moved to Washington, DC to live with her mother and to work as a beautician. She maintained her job approximately for three years, at which time she had her second psychiatric episode and moved to Greensburg where her grandfather was living. She was placed in Westmoreland Hospital psychiatric ward for approximately 2 months. Following her hospitalization, she went to live with grandmother in Squirrel Hill. She refused follow-up after discharge. While at her grandmother's she obtained a job as a beautician in Pittsburgh and later in East Liberty. Her schizophrenia was in remission from 1976 to 1978 when she developed her third psychotic episode. She was again hospitalized at Westmoreland Hospital for approximately two months and transferred to Torrance Hospital where she remained from December 1978 to February of 1980.

Patient was born in Pennsylvania. She denies any perinatal or developmental problems. She denies any serious family problems while growing up. However, she stated the household consisted of her mother, grandfather, grandmother, patient, three siblings, and several aunts and uncles. (Patient's grandmother had 14 children and most of the children remained in the household.) Patient's mother married in 1955 when patient was 3 years of age. Patient's mother had 4 children to this marriage; subsequently, patient has three half brothers, two of whom are twins, and one half sister. When patient was ten years of age, family moved to N.B. She was in the fourth grade at that time. Patient states that she had difficulties at school in the fifth grade. She left school after 10th grade at the age of 17 in 1969.

The patient carries a diagnosis of a Seizure Disorder which was diagnosed in 1985 at St. Francis Hospital. Apparently at that time the patient suffered 2 seizures following what was felt to be a neuroleptic malignant snydrome treated with Prolixin. At that time, her CPK and temperature were elevated. An EEG at that time was read as showing a possible focal abnormality in the frontal lobes. She was started on Dilantin and Phenobarbital and was discharged on Dilantin. She has had no further seizures since 1985. She also has a history of beta-thalessemia minor as well as iron deficiency anemia. She reports a history of rheumatic fever as a child. She has no known sequelae except for a possible heart murmur. She acknowledges a history of alcohol and marijuana use in the past. She has no known drug allergies. Physical examination was remarkable for moderate obesity. Neurological examination was nonfocal.

Hospital Addmission - 1988

This black female is known previously to WPIC and TLC but most recently has been followed at St. Francis Hospital. She has a probable history of medication noncompliance. She presented initially to St. Francis emergency room on the night prior to admission with multiple somatic complaints. At the time of her presentation to the DEC, she complained of auditory hallucinations, visual hallucinations consisting of visions in the sky and seeing things in people's faces, a fear of crowds, concerns that she will be murdered, feeling that others talk about her and receiving messages from the television. She denied any suicidal ideation but was concerned that the voices or fear of others will force her to hurt herself in some way. There is no homicidal ideation. She reported decreased sleep and decreased appetite. There are no depressive symptoms. She acknowledged a past history of alcohol and marijuana use but none currently and has no other history of any other drug use or IV drug use. She acknowledged "missing" some medication doses but it was unclear at the time of admission how much or how often she would miss taking her medications. She says that her aunt brought her down from D.P., just north of Pittsburgh on the night prior to admission, but that she actually lives in Oakland. She has her own apartment and lives independently with SSI. She has a sporadic work history. She reported no recent stressors.

Narrative Summary of Treatment Course

Problem #1: PSYCHOTIC DISORDER. The patient was admitted to the 11th floor for a full evaluation. On admission, her mental status examination showed her to be alert and appropriately dressed and groomed. She appeared quite anxious and somewhat guarded but was cooperative. She presented her history in a vague manner and was unclear about many historical details. Her mood was described as "frightened." Her affect was blunted, anxious and nonlabile. She admitted to auditory and visual hallucinations, paranoid delusions and ideas of reference related to the television. There was no suicidal or homicidal ideation. Her thoughts were generally well organized. Her insight was very poor and her judgment was impaired. She appeared somewhat restless, and there was mild cogwheeling on exam. The patient was initially started on her reported dosage of Haldol of 35 mg per day. However, there was some question of the patient's compliance, and she did appear to have mild extrapyramidal side effects. The Haldol was decreased to 10 mg b.i.d. which was tolerated well by the patient and her restlessness appeared to resolve. In addition, she was treated with Cogentin 2 mg b.i.d. During the course of her hospitalization, the patient showed a gradual improvement in her symptoms. Our impression was that the patient probably had not been taking her medications as prescribed as an outpatient. At the time of her discharge, the patient was in stable condition. She was greatly improved and had no evidence of auditory or visual hallucinations, paranoid ideations or other type of delusional ideas. She was tolerating her medications quite well. There was no evidence for any suicidal or homicidal ideation. The patient was able to go out on pass on one occasion prior to discharge, and this went well. In addition, education was provided for the patient regarding her follow up care as well as the importance of her medications with the stress being on the patient's compliance. The patient agreed to continued follow up through WPIC. In addition, the patient was able to attend 2 sessions at TLC during this hospitalization and will continue there as an outpatient.

PROBLEM #2: SEIZURE DISORDER. The patient's history was suggestive of an isolated seizure event. She has no previous seizure history and has had none since 1985. A sleep deprived EEG was obtained and the results were essentially unremarkable. It was elected to taper and discontinue the patient's Dilantin in light of the present findings. The patient's initial Dilantin dosage on admission was 400 mg per day. This was decreased to 200 mg per day prior to her discharge. The patient was given a 5 day supply which she would stop after the five days.

PROBLEM #3: ANEMIA. The patient initially presented with a mild anemia and a greatly reduced MCV. Her iron supplementation was discontinued and iron studies were obtained which showed evidence for an iron deficiency anemia. In addition, her old medical records were reviewed and it was felt that the patient in the past has had a mixed picture of beta-thalessemia minor, iron deficiency anemia and anemia of chronic disease. With the low iron studies, it was felt that the patient should be restarted on iron supplementation and treated for a period of six weeks. At that time, her blood studies can be repeated and reevaluated.

Hospital Admission - 1989

The patient is known to WPIC by an inpatient admission from 5/17/88 to 6/1/88 on the 11th floor. Patient has been followed up at TLC since then and has been treated with Haldol 10 mg b.i.d. and Cogentin 1 mg b.i.d. Patient was referred today by her TLC therapist, who was recommending admission.

The patient reported that she had been feeling quite well and was going to TLC three days a week and taking her medicine until three weeks ago. She went away to visit her mother in Virginia and she stopped taking her medicine. She said that she stopped taking it because she felt very good and she thought that she didn't need it anymore. She reported that the vacation was a positive time, although her mother worked each day and she was at home by herself and began to feel quite bored and lonely. Her mother was also talking with her about having the patient come and live in Virginia with her and the patient was not open to that idea. She stated that she returned to Pittsburgh on 5/27/89 and since then she has been feeling "real bad." She has not been able to sleep and will stay up all night long playing her stereo, her appetite is decreased, she is experiencing increased energy with restlessness and pacing and decreased concentration with racing thoughts. She reports that she has been "fantasizing and not in touch with reality." She said that her fantasies include being married and having children, and being a recording star, and having a good job and being very rich. She has not returned to TLC since she came back from vacation and she has not called her therapist. Today Ms. F. called her and asked her to come in to TLC to speak with her. At first the patient was reluctant to do so but then she agreed. She reported all of her symptoms and her noncompliance to medication to her therapist who recommended that she come up to the DEC to be admitted. Patient also reported that for the past several days she has been keeping to herself in her CRR apartment and not talking with her roommates; she's locked herself in the bedroom and she has not been showering nor taking care of her personal hygiene. She reports talking to herself and carrying on conversations with herself and laughing out loud. She stated that she has not been hearing voices but been "manufacturing voices in her head and making up voices." She states that she is getting messages from the TV and the radio, although she is not able to say what those messages are and she feels that people are watching her. She reports that if she stares too long at the floor or at the walls, she will begin to see Jesus Christ or the devil.

The patient admitted to some passive death wishes thinking that life is not worth living but she denied any suicidal ideation or plan. She denied any homicidal ideation but she stated that in the past when she has gotten sick, she would hear a voice telling her to get a machine gun and to start shooting people. The patient stated, "I'm afraid that that might happen again." She denied any drug or alcohol use but she stated that when she drinks Pepsi or water she pretends that it's beer and that she is drinking alcohol and smoking cigarettes. The patient stated that she does not know why she stopped taking her medicine when she knew she was going to get sick. She stated that she feels that she needs to be in the hospital in order to prevent herself from getting worse.

PHYSICAL EXAMINATION - 1990

VITAL SIGNS: Weight: 196. Blood pressure supine: 122/76. Standing blood pressure: 118/84. Pulse: 82 and regular. Temperature: 35.6 degrees C. Height: 63 inches. Respirations: 20 per minute.

GENERAL APPEARANCE: Obese black female in no acute distress.

SKIN: Warm and dry, the turgor is good.

MUSCULOSKELETAL: Negative for joint deformity or effusion. There is an increased lumbar lordosis.

HEENT: Normocephalic, atraumatic. The funduscopic exam is unremarkable for AV nicking, hemorrhage or exudate. The TMs are intact and pearly gray, the breath roads are clear, the oral cavity and pharynx are unremarkable for inflammation or lesion.

NECK: The thyroid is of normal size and consistency.

GLANDS: No lymphadenopathy is noted.

BREASTS: Negative for masses or nipple discharge.

LUNGS: Clear to auscultation and percussion.

CARDIOVASCULAR: Regular rate and rhythm without murmur, gallop, click or rub, there are no bruits, there is no peripheral edema. The pulses are intact and equal bilaterally.

ABDOMEN: Obese, soft and non-tender with normoactive bowel sounds and no masses or organomegaly.

GENITALIA: Normal pap smear in Sept. 1989. Not due yet.

RECTAL: Normal exam Sept. 1989. Not due yet.

NEUROLOGIC: Alert and oriented x 3, the cranial nerves and cerebellum are intact. Reflexes are 2+ and equal bilaterally, the plantar is downgoing bilaterally, the sensory and motor systems are intact. No tremors or focal neurologic signs are found.

TEST SCORES

WAIS (1980)

VIQ	93
PIQ	80
FSIQ	87

Information	9	Picture Completion	8
Digit Span	9	Picture Arrangement	6
Vocabulary	9	Block Design	5
Arithmetic	8	Object Assembly	7
Comprehension	9	Digit Symbol	8
Similarities	10		

"The 13 point difference between her verbal and performance I.Q. reflected psychomotor retardation which may be related in a general way to her emotional problems. Inter-test scatter was relatively narrow. On performance tests she tended to perseverate in incorrect solutions and to approach problems in a disorganized trial and error manner. Higher intellectual potential is probable."

WRAT-R (1989)

	S.S.	**Percentile Rank**
Reading (Recognition)	98	45
Spelling	108	70
Arithmetic	87	19

Gates-MacGinitie

	S.S.	**Percentile Rank**	**Stanine**
Reading Comprehension	88	22	3

Career Ability Placement Survey

	Primary Abilities	**Stanine Score**	**Percentile Score***
1MR	MECHANICAL REASONING	5	50
2SR	SPATIAL RELATIONS	3	15
3VR	VERBAL REASONING	4	35
4NA	NUMERICAL ABILITY	3	20
5LU	LANGUAGE USAGE	7	85
6WK	WORD KNOWLEDGE	7	75
7PSA	PERCEPTUAL SPEED AND ACCURACY	3	25
8MSD	MANUAL SPEED AND DEXTERITY	3	20

*NOTE: PERCENTILE SCORES ARE BASED ON Z-SCORES AND ARE NOT CALCULATED FROM THE STANINE SCORE

SUMMARY OF PERFORMANCE - VOCATIONAL ASSESSMENT, 1990

Work Behavior and Functional Physical Capacities

Gladys demonstrates a sound awareness of appropriate worker behavior. She consistently reports to her correct work area on time and completes assigned projects as scheduled. She attends to verbal instructions and attempts to follow through with supervisory suggestions. She maintains a positive work attitude and adequate frustration tolerance for challenging work tasks. Her social interaction skills with co-workers and supervisors are also positive for the work situation.

Gladys is able to follow a daily work schedule and independently initiate familiar work tasks. She maintains a clean work area and is able to find materials needed to complete job responsibilities. She demonstrates a working knowledge of common kitchen utensils and handles equipment and food items appropriately. She abides by rules and regulations of the work situation and demonstrates adequate personal hygiene skills necessary for working in food service. Gladys demonstrates the prerequisite skills for food service entry level positions; however, she may need further training to strengthen basic skills (e.g., needs to improve measurement skills and understanding of cooking terms and following written recipes which she may encounter in some jobs).

Gladys is able to maintain at least a six hour work day involving light duty work. She is able to maintain work tolerance for standing, stooping, bending and reaching without any significant indications of fatigue. However, her work production would not meet the demands for the fast food industry. Also, given her history of emotional illness, it is recommended that she participate in work situations which involve minimal amounts of time pressures. It appears that she is better suited for food service positions which provide more structure and fewer interruptions or variations from daily routines.

Gladys demonstrates a sound awareness of her how disability impacts her ability to function in various work settings. She acknowledges that employment positions which involve high levels of responsibility, high production demands and performance levels under stress are inappropriate. She also seems to acknowledge the importance of adherence to her medication regime and individual therapy in order to maintain daily functioning and employment. Throughout this evaluation Gladys did not exhibit any symptoms related to her schizophrenia. She was able to function adequately in work situations which involved mild to moderate stress levels.

Cognition and Learning Ability for the Work Environment

Gladys' learning ability is enhanced when provided concrete directions that are accompanied by visual demonstration or a model. She experiences greater difficulty on tasks which require more abstract thinking. Her proficiency in learning and organizing increases for concrete tasks that involve manual manipulation of materials. She has greater difficulty manipulating and organizing verbal information and concepts in the absence of a concrete reference. Her performance on the Perceptual Memory Task indicates that her ability to learn through visual and auditory modes is in the average range. Observation during the administration of the test also reveals that she is strategic and flexible in her approach to learning new tasks. However, her lack of confidence and tendency to become anxious when confronted with new or challenging tasks may impede her learning rate. Gladys is capable of reading and comprehending concrete instructions but would have difficulty handling written language which requires a high degree of moderately complex conceptualization. Based on her academic achievement and her performance during the evaluation, it is felt that Gladys is better suited for training programs which emphasize practical application, provide an opportunity for repetition of newly learned skills, and allow for self-pacing.

Summary and Recommendations

Based on data and information obtained through the evaluation, it would appear that Gladys is capable of working at a competitive level. She appears to possess a strong work ethic and excellent worker behaviors which could enhance her employability. Gladys appears to have adequate insight into her vocational weaknesses, yet appears to underestimate her abilities and will require support in recognizing her strengths. Gladys also acknowledges the importance of adherence to her prescribed medication regime and maintenance of individual therapy in order to control/manage her schizophrenia.

Gladys' career interest remains in the food service occupations. She desires employment as a food prep and/or baker working in a hospital, institution, or cafeteria type setting. However, at this present time, she needs to strengthen her specific skills and increase her knowledge base and self-confidence in order to enhance her employment potential and secure a position in the food service field. To assist Gladys in achieving her vocational goal the following is recommended:

1. Participation in Community College of Allegheny County Food Service training program for special needs adults. This training program could allow for self pacing and practical application of learned skills for Gladys. Emphasis in training should include strengthening basic skills (e.g., following written instructions for recipes, measurement skills, cooking terms, safety judgment and procedures including appropriate care, and use of equipment operation). Programming should also include a transitioning phase, or a gradual reentry into the work force by providing a practicum placement so that Gladys can increase confidence levels and be given support to practice skills learned in the classroom and gradually adjust to the demands of a competitive employment situation.

2. Upon completion of this program, Gladys should be provided with job placement services. Services should include the identification of appropriate job matches with respect to skill level and production demands. Stressors inherent to various job settings (such as with the fast food industry) should be considered when placing Gladys on the job. Gladys would also benefit from job search skills training and job interview skills training.

3. Continued involvement in individual therapy and maintenance of present medications for the management of schizophrenia.

CRR PROGRAM FUNCTIONING - 1991

Gladys has been functioning well during this review period. She consistently sets and keeps all appointments in a timely manner.

Gladys attends the cooking group at the CFC occasionally. Gladys successfully hosted a spaghetti dinner for the CFC consumers. Gladys has not been able to participate in as many CFC functions due to her work schedule at Magee Women's Hospital.

Gladys maintains a positive relationship with her friends at CFC and in the community.

Gladys' relationship with her mother who lives in Virginia and her grandmother who lives in Pittsburgh is a very positive one.

Gladys told me "that the CFC has helped her so much and she does not know where she would be without it."

Gladys also stated "that she would like to start working on the possibility of moving, to supportive housing, maybe in a year."

Gladys enjoys her house and roommates.

Day Programming/Vocational

Gladys continues to work at Magee Women's Hospital 17 to 18 hours a week. Gladys works as a cook in the dietary and nutrition department. Gladys enjoys her job very much and has made it known to her supervisor that she would like to work more hours if they are made available.

Gladys attends special events at the CFC and enjoys coming to the cooking group whenever she has the time off from work.

Income

$399.84	Magee Women's Hospital
211.99	SSI
$611.83	per month

Current Medications

Ferrous sulfate	5 grams 3 times a day with food
Diphenhydramine 50 mg	Two tablets at bedtime
Feldene 20 mg	One tablet at bedtime
Folic Acid 1 mg	One tablet at bedtime
Haloperidol 1 mg	One tablet at bedtime

Medical Issues. None at present. Gladys' last checkup was in late August and she is doing very well.

Service Plan Goals Accomplished

Gladys has made it known to her supervisor that she would like to increase her hours of employment. Gladys will work more hours when they become available.

Gladys has a long term goal, that is known by her supervisor, to work full time.

Gladys has made progress on budgeting her monies to cover rent, food, etc.

Service Plan Goals to Continue

01 Gladys will build social networks:

-- Gladys will explore adult social activities
-- Gladys will look into Peoples, her church and other agencies for adult social information
-- Gladys will maintain her current social networks, CFC and other friends

02 Gladys will work on budgeting to save money to purchase house supplies for her expected move in the future:

-- Gladys will work on long term savings
-- Gladys will identify items needed to purchase
-- Gladys will utilize the money management group to help her work on these goals

RECOMMENDATIONS

It was recommended by participants in the UR meeting that staff work quietly but continuously on those things Gladys needs to do or learn in the next year, preparatory to moving out of the program.

Concern was also expressed over Gladys' wish to live alone after leaving the program. Staff should explore with her her living situation before she moved into the program and help her to realize that the support of a roommate, even one who nags her, may be crucial to her ability to live without housing support.

EDUCATIONAL/EMPLOYMENT CHRONOLOGY

1969	Left High School at end of 10th Grade
1971	Morrowfield Beauty School - Beautician's license
1972-74	Worked as Beautician
1975	" "
1976	" "
1980	GED
1980's	Council Thrift Shop - Bagger/Clerk
1988-89	Telephone sales for insurance marketing firm
1991-present	Magee Women's Hospital - Food Service

Vocational Readiness and Job Placement: 1989 to Present

Gladys was referred to Neuropsychological Assessment and Rehabilitation Services (NARS) on 9/19/89 by her primary clinician in WPIC's partial hospitalization program (TLC) for "assessment of readiness for vocational training and/or job placement." Gladys had been attending TLC three mornings per week for the past year and participating in Womens' Group, Needlework, Music Group, and the Breakfast Club. Her symptoms of schizophrenia had been in remission since June 1989 when she was hospitalized for a one week period in order to restart her medications, which she had discontinued during a visit with her mother in Virginia because she "felt so good." Medication regimen included Haldol Decanoate 25 mg IM q 4 weeks, Haldol 5 mg qHS, Cogentin 1 mg qHS, and Benadryl 50 mg qHS. Gladys was supported by $400.00 per month from SSI and $24.00 per month in Food Stamps; her rent at the Community Residential Rehabilitation facility (CRR) was $185.00 per month. Gladys was unemployed at the time of her referral to NARS and had last worked from 12/88-2/89 doing telephone sales but was unable to meet the daily quotas. Prior to this job she had worked from 3/82-7/83 as a clerk/bagger for a local Council Thrift store.

Due to staff shortages within NARS, Gladys was placed on a waiting list for services until 11/2/89 and was seen on a twice monthly outpatient basis for the next four months. She was consistently pleasant, cooperative, and well invested in sessions. Initially she was adamant in denying interest in any type of educational or training program and expressed her vocational goal as an entry-level job in food service or the clerical field. Rehabilitation plan was focused toward further clarification of employment objectives and enhancement of job seeking skills. Psychoeducational and vocational assessments were completed, job applications were obtained and completed, and referral to the Office of Vocational Rehabilitation (OVR) was agreed upon for job placement assistance, possibly in a supported employment position. OVR intake and all necessary supporting documentation were complete by March 1990, but Gladys's assigned counselor went on an emergency medical leave of absence until July 1990. OVR desired that Gladys undergo a 7 day, "hands-on" work evaluation in her identified area of interest (food service) at the Rehabilitation Institute of Pittsburgh, which was immediately undertaken and successfully completed (see previous work evaluation). When presented with the option of pursuing further "hands-on" training in the food service field in a program known for thorough training and excellent job placement rates for graduates (Community College of Allegheny County), Gladys changed her mind about "schooling" and became quite excited about the program. She began the two semester, 5 days per week training program on 8/25/90 and enjoyed immediate success, earning 100% on exams, "Student of the Week" award, and a Certificate of Achievement at the first semester's end. The only negative feedback which she received was that her facial expression did not always express how she was actually feeling but she was able to discuss this with her teachers. During training, Gladys kept in regular contact with NARS by telephone, and came into the clinic over Christmas break. In January 1991 she interviewed successfully for a 4-week practicum in the Dietary department of a local hospital. She found her initial employee-trainer problematic and her school instructor was able to have another trainer assigned to her. She worked for two weeks packaging, delivering and collecting cafeteria trays, and for two weeks directly in the cafeteria. She was hopeful of receiving a job offer from the hospital, and was hired on a part-time basis on 3/16/91. Her work hours fluctuated between 7:00 a.m. to 3:30 p.m. and 4:00 p.m. to 8:00 p.m.. The OVR provided work uniforms, shoes, and two monthly bus passes, as well as ongoing assistance in money management and budgeting.

Gladys made several urgent telephone calls to her NARS clinician during her first full month of employment, requiring immediate and extensive intervention during this already stressful, transitional time. On April 4, 1991 Gladys reported confusion about the effects of earned income on her SSI benefits because she had been given contradictory information by NARS, OVR, and the Social Security office. The correct income deduction and reporting guidelines were reviewed with her and she expressed a sufficient comprehension of these.

Gladys telephoned again on April 23, 1991 and was quite upset and confused regarding health insurance. As she was unable to afford the cost of traditional Blue Cross/Blue Shield insurance, she had selected a Health Maintenance Organization (HMO) during her new employee orientation. She had proudly taken her new insurance card and pay stubs for a new financial interview at WPIC, as a change in income or insurance requires. She was dismayed at being informed that WPIC was not on her HMO's list of approved providers and that Medical Assistance could not continue to pay for her psychiatric treatment because they viewed her HMO as a primary insurance carrier. Gladys's NARS clinician clarified this situation with her HMO, and Gladys was to be scheduled with an approved HMO service provider within the week as she was due for her monthly Haldol injection. Three days later, Gladys called back very upset and confused about why her HMO had scheduled then canceled her new doctor's appointment. The HMO had excluded Gladys from psychiatric coverage due to the presence of a pre-existing condition, a chronic illness, and the receipt of disability payments. Medical Assistance agreed to continue coverage upon receipt of this in writing, and Gladys continues to receive her primary psychiatric treatment and long-term supportive services at WPIC. She will continue to pay $32.00 per month for HMO coverage of physical conditions until she can drop this coverage at open enrollment time because it is redundant with Medical Assistance.

As of March 1992, her one year employment anniversary date, Gladys had made an excellent adjustment to her part-time competitive employment and continued to report much personal satisfaction and improved self-esteem secondary to working.

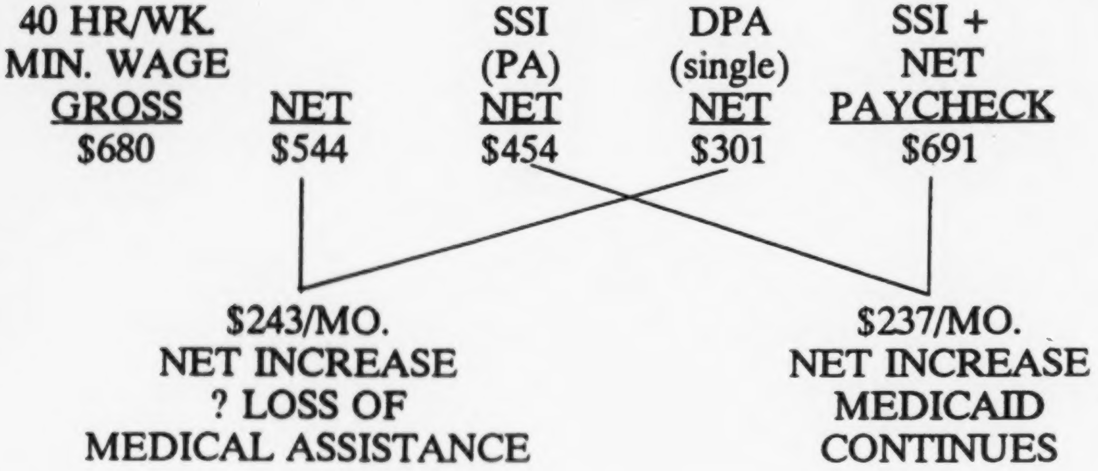
GLADYS

$6.03 /HR WAGE
x 80 HR/MO
$482 GROSS = $386 NET
- 65 EXCLUDED
$417 ÷2 = $209

$454 SSI
-209 DEDUCTION
$245 NEW SSI CHECK
+386 NET PAY
$631 TOTAL NET

= $177/MO. INCREASE
- 50/MO. RENT INCREASE
- 32/MO. HMO COST
- 40/MO. BUS PASS
$ 55/MO. "REAL" INCREASE

= $0.69/HR.



40 HR/WK. MIN. WAGE GROSS	NET	SSI (PA) NET	DPA (single) NET	SSI + NET PAYCHECK
$680	$544	$454	$301	$691

$243/MO.
NET INCREASE
? LOSS OF
MEDICAL ASSISTANCE

$237/MO.
NET INCREASE
MEDICAID
CONTINUES

INCREASE MAY BE OFFSET BY:

1. ↑ Rent
2. ↑ Transportation Costs
3. ↑ Utilities

$680	/MO. GROSS = $544 NET
- 65	SSI Excludes
$615	÷2 = $307
$454	Regular SSI Check
-307	$1 deduction/$2 earned
$147	New SSI Check Amt.
+544	Net Monthly Paycheck
$691	TOTAL Net Monthly Income ($237/mo. > SSI only)

CASE CLOSURE

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
DISCHARGE SUMMARY

NAME:
HOSPITAL NUMBER:
DATE OF ADMISSION: 8-21-95
DATE OF DISCHARGE: 7-2-96
PROGRAM: PRAS
ATTENDING: Rosyvee Guzmán, B.A.
Michelle Geckle, MEd, CRC

Ms. is a 21 year old, white, single mother of a 7 year old son. Ms. was referred to Psychiatric Rehabilitation and Assessment Services (PRAS) on 8-21-95 by Nina Bridenbaugh, LSW of the Comprehensive Care Program (CCP) of Western Psychiatric Institute and Clinic (WPIC) for vocational services. Ms. presented to WPIC on 11-9-94 with different symptoms of depression. It appears that her symptoms began soon after the 7/94 death of the main support in her life, her maternal grandmother. Diagnoses as of 11/94 include Major Depression Single Episode, Rule Out Major Depression, Recurrent, Other Specified Family Circumstances, Asthma, Physical Abuse and self-defeating and dependent traits. She was pregnant throughout her 9th grade year and gave birth to her son in 6/89 at age 15. Her work experience is limited primarily to "under-the-table" babysitting and yardwork. Ms. is support by Welfare (cash benefits of $320.00/month) and food stamps. She took cosmetology in vocational technical classes in high school. In her last session at PRAS on 4-3-96, Ms. expressed plans of moving out of her mother's house and starting a landscaping job.

Ms. kept 14 appointments in PRAS, frequently cancelling or not appearing for scheduled sessions. Treatment provided for Ms. included assistance in planning for an educational/training program, exploring career options with resource materials, verifying program costs, financial aid sources, applications and admission forms, schedule of courses and credits, and help with child care.

Ms. has not responded to attempted contacts following her absence at three consecutive appointments. Therefore, her case is closed.

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WESTERN PSYCHIATRIC INSTITUTE AND CLINIC
DISCHARGE SUMMARY

NAME: HOSPITAL NUMBER:
DATE OF ADMISSION: 4-18-88 DATE OF DISCHARGE: 6-14-89
PROGRAM: NARS ATTENDING CLINICIAN Michelle Geckle, M.Ed. (

, a 32 year old, white, married female, was referred to NARS on 4-18-88 by D. Mazzie, RN, MSN of the Mood Disorder Clinic for assistance in exploring career and educational opportunities. Diagnoses at referral were Dysthymic Disorder and Major Depression, Recurrent. Cathy had received treatment for depression since 1979 and was followed in the Center of Psychotherapy Training by K. Gaitskill, M.D. since 5-5-88.

Cathy presented to NARS with a history of having held a number of what she considered to be unskilled or semi-skilled jobs, i.e.: receptionist, nurse aide, billing clerk, pipefitter, and most recently, order filler in a warehouse on a seasonal basis. She expressed a desire to undergo vocational assessment and career counseling to help develop long-term and potentially more satisfactory career goals. She specifically desired a college-level education, having completed half of a 2 year Electronics Technology Training Program at Penn Technical Institute in 1986 under Office of Vocational Rehabilitation sponsorship and found it "too boring".

Cathy was seen for a total of 14 individual sessions over a period of 13 months. She was generally, prompt, articulate and invested in career exploration and activities related to selecting a college and an educational program. Services provided for Cathy included vocational assessment (please see NARS Interim Summary), career counseling and guidance, and referral an liaison services with the Office of Vocational Rehabilitation, counselor Mary McCloskey and then Bob Shields, and with CCAC and The University of Pittsburgh.

Full Office of Vocational Rehabilitation sponsorship was secured for Cathy and she entered · Campus in 1-89 taking 17 credits. She earned a 3.82 QPA at midterm which she maintained through her final exams. At her last session in NARS on 5-22-89 Cathy had registered for 16 credits for the Fall 89 semester, and was back working at the warehouse for the summer. Her plan was to transfer to the University of Pittsburgh after 2 years at CCAC into the Business/Liberal Arts Dual Major Program. She did not feel in need of any further services from NARS at this time but felt that she may like some assistance with job search issues near the time of her graduation. She may be referred back to NARS for this purpose at that time.

Michelle Geckle, M.Ed., CRC
Neuropsychological Assessment
and Rehabilitation Services

ITEM #803800

University of Pittsburgh

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

NEUROSPYCHOLOGICAL ASSESSMENT AND REHABILITATION SERVICES

Discharge Summary

Name:
WPIC #:
Admission Date: 12/7/
Discharge Date: 2/16/

, a 31 year old white single female, was referred to Neuropsychological Assessment and Rehabilitation Services on 11/10/83 by Lloyd Benjamin, M.D., of the 10th floor Mood Disorders Module for a vocational assessment and assistance in investigating alternate employment opportunities. Ms. is known to Western Psychiatric Institute and Clinic and has been followed actively on an outpatient basis by Steven Sittenfield, M.D., Corporate Services, since 10/19/82; diagnosis is Borderline Personality Disorder.

Ms. has been employed full-time for the past 14 years as an operator for Bell Telephone, since her graduation from high school. She reported finding her employment stressful and anxiety-producing. At the time of her referral, Ms. presenting problems included the following: (1) difficulty with the decision to remain at her present job for two more years (in order to receive 85% retirement benefits) or to seek alternative employment; (2) uncertainty regarding her current vocational abilities, interests, and potential; (3) lacking adequate and accurate information regarding feasible and realistic occupational alternatives.

Ms. was seen in N.A.R.S. for a total of nine sessions from 12/7/83 to 2/16/84, after having cancelled two initial appointments. She was consistently on time for sessions, casually dressed, but rather sloppy in appearance at times. Ms. was able to discuss her work-related concerns openly, but seemed reluctant to take responsibility for making decisions or initiating changes regarding her present employment situation. She often conveyed the impression of being overwhelmingly confused and helpless regarding the nature of N.A.R.S. services, as well as treatment plan goals and methods. Two sessions were necessary in order to clarify her expectations of N.A.R.S. clinician, her presenting problems, and treatment goals.

As requested by Dr. Sittenfield, treatment for Ms. was time-limited (six weekly individual sessions following completion of her treatment plan), and primarily informational in nature. A vocational assessment was completed and the results were interpreted and discussed with Ms. . Career, educational, and occupational information from various resources was provided and discussed in sessions. The pros and cons of her current job vs.

feasible alternatives were a major topic of discussion, and during her final session Ms. related that she had reached the decision to remain at her present job, at least for two more years, and felt comfortable with this decision. She planned to put in another transfer request in June, 1984, which will mark one year of perfect attendance for her. All of her previous transfer requests have been denied on grounds of excessive absenteeism secondary to multiple hospitalizations. Ms. also acknowledge that she had gained an adequate understanding and knowledge of her current level of vocational functioning and potential, as well as a more comprehensive knowledge of employment and career alternatives.

In reviewing her treatment plan, Ms. concluded that she has attained both of her initial goals, and no longer felt in need of further services from N.A.R.S. clinician.

Michelle Geckle

Michelle Geckle, M.Ed.
Specialty Counselor

MG:bam
Dictated: 3/14/84
Transcribed: 3/14/84